Includes research reports

For Patients' Sake

Patient First Review Commissioner's Report to the Saskatchewan Minister of Health

Tony Dagnone, CM, FCCHSE
Commissioner, Patient First Review

PatientFirst

October 2009

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October 2009

To The Honourable Don McMorris
Minister of Health

I am pleased to present the findings and recommendations of the Patient First Review, *For Patients' Sake.* My report is founded on the voices and perspectives of health care patients and their families, providers and system leaders, as detailed and analyzed in reports and recommendations I have received from consulting firms KPMG and Deloitte.

I have been honoured to lead this defining review on behalf of all those who want the health system to care more about them. I continue to have a strong affinity to Saskatchewan, which I was proud to call home for more than 40 years.

As Commissioner of the Patient First Review, I directed two distinct but related inquiries. One focused on the patient experience of care, while the other addressed the management of the health system. The patient experience component challenged me to bring forward recommendations for fostering a culture that would provide timely, quality, safe care to all Saskatchewan residents regardless of their postal code. The challenge embodied in the administrative component of the review was to advance a "new way of doing business" and thereby improve the performance of the health care enterprise.

Unlike previous reviews of the health system, the Patient First Review is unique in its focus on the care and caring experience. The term patient is used broadly in this report and represents patients, clients, and residents who receive a variety of health services that go beyond the treatment of illness or injury. Patients were given the first and last voice in the research, and by the time the public research was completed, approximately 4,000 Saskatchewan residents had shared perspectives, ideas and opinions. What we heard from them became the foundation for consultations with health care providers and health system leaders. Our approach embodied a candid, unabashed dialogue with those who seek to improve the delivery of patient care in the province, followed by the development of recommendations for high-impact change based on the advice received. Patients, health care providers, and health system leaders participated with honesty and openness to meaningful change.

Patients were given the first and last voice in the research, and by the time the public research was completed, approximately 4,000 Saskatchewan residents had shared perspectives, ideas and opinions.

Using a combination of focus groups, personal and telephone interviews, online submissions, a weblog, and a telephone survey, Patient First researchers gathered significant qualitative and quantitative data from patients and their families, health care professionals and workers, managers and system leaders. This data is reflected in a summary report prepared by KPMG and its research partner, available at www.health.gov.sk.ca/patient-first-review. Additionally, the conclusions of the administrative review directed by Deloitte offer avenues for transformational change and improved system performance in concert with and beyond the recommendations contained in my report.

The Patient First Review has examined the patient experience and the administration of the health system with attention to both strengths and concerns. There are many positives to build upon; however, in order to achieve the vision of a patient- and family-centred health system, policy makers, health system leaders and health care providers will need to address the concerns identified in this report.

The research findings make clear that those associated with health care must renew their commitment to putting the patient first. Patients ask that health care workers and their respective leadership see beyond their declared interests so that the interest of patients takes precedence at every care interaction, every future contract negotiation and every policy debate. Only in this way will we achieve a patient- and family-centred health system for Saskatchewan citizens. Similarly, government leaders and policy makers must keep the patient front and centre when policies, programs, and new models of care are designed and implemented.

Patients ask that health care workers and their respective leadership see beyond their declared interests so that the interest of patients takes precedence at every care interaction, every future contract negotiation and every policy debate.

Patients spoke volumes on their desire to receive timely access to quality care from the most appropriate programs, delivered by the most appropriate professionals and skilled workers. Their collective message to me was, "Action, not more words." I share this bias for timely action. While patients accept that change can be difficult, this report provides evidence of the need for significant change to the health system's culture and some of its modes of service delivery.

One of the most striking features of our consultations was the level of agreement we encountered between patients and providers concerning the areas of Saskatchewan health care that need to be strengthened. After hearing the themes and stories shared by patients, the providers we met with consistently affirmed their views and perspectives. There is great potential in this province for an alignment of patient-provider interests that could have a profound impact on how health care is modeled and delivered.

Any prescription for bold change will be met by resistance from some interested parties. As you and your colleagues and advisors review and consider the following findings and recommendations, it is my hope that the overriding consideration will always be the interests of the patient.

Change is a constant phenomenon to which the health system is not immune. You initiated this unique review in order to improve both the patient experience and the efficiency and effectiveness of the health system. This report and its recommendations represent the start of a change journey. What is required now is resolve, leadership, commitment, and courage on the part of all.

For the sake of patients, I call upon the Government of Saskatchewan to implement the recommendations that follow to ensure that no patient is excluded when it comes to living up to the core promises of Medicare. And I call upon health system leaders and health care providers to adopt and practice the values that support a truly patient- and family-centred health system.

I call upon health system leaders and health care providers to adopt and practice the values that support a truly patient- and family-centred health system.

Saskatchewan, the birthplace of Medicare, can now seize the opportunity to reframe, rejuvenate, and ingrain a caring attitude and culture that offers dignity and compassionate care to all patients. I am confident that the people of this proud province can respond to the challenges before them.

Tony Dagnone, CM, FCCHSE
Commissioner, Patient First Review

cc: **Dan Florizone, Deputy Minister of Health**

Acknowledgements

My report is dedicated to those patients who believe in Medicare but want a health system in Saskatchewan that cares more about them.

While I remain responsible for the contents and conclusions of this report, many individuals played significant roles in bringing this project to fruition. I would like to acknowledge:

The Honourable Don McMorris, Minister of Health, for boldly initiating the Patient First Review and affording me the opportunity to serve as its independent Commissioner;

The dedicated health care providers and health system leaders who gave of their valuable time to offer their perspectives and expertise in the interest of improving health care delivery for their fellow citizens;

The researchers and consultants with KPMG, Innovative Research Group, and Deloitte, for their valuable expertise and our spirited dialogues throughout this review;

Dan Florizone, the Deputy Minister of Health, and his leadership team, for making this review their collective priority;

Staff at the Ministry of Health, for their outstanding cooperation and assistance throughout the entire review process; and

Finally, and most importantly, all those patients and family members who came forward to share their stories, through focus groups, individual interviews, and online submissions. It is not an easy task to recount personal, difficult, and painful experiences. Their courage and honesty will help pave the way for profound and lasting change. Thank you also to the individuals who agreed to have their photographs included in this report.

Saskatchewan people responded to the Patient First Review with great interest and high hopes for positive change. I was overwhelmed at times with requests from individuals and organizations who wished to share their perspectives with me. I extend my regrets to those with whom I was unable to consult due to time or logistical limitations.

While this report will not serve to 'fix' every problem identified by every patient, its conclusions have been tempered and sharpened by the voices of these individuals.

My report is dedicated to those patients who believe in Medicare but want a health system in Saskatchewan that cares more about them.

Why a Patient First Review?

Must changes be made to Saskatchewan's health system? Absolutely.

On the surface, the system seems to be performing relatively well. Most people who interact with the health system indicate a measure of satisfaction with their experience.

'Good' however, does not necessarily mean `good enough'. Saskatchewan residents continue to pay high costs for health care services that do not appear to offer high value. Rather, the system struggles to meet demand and maintain basic safety and accessibility standards while often failing to adopt practices that ensure high quality. And for those whose experiences in the system are not positive, the consequences can be profoundly upsetting – even dire. With health and lives at stake, nothing less than excellence should be expected of a system in which all Saskatchewan citizens have a share.

Nothing less than excellence should be expected.

Growing pressures

Saskatchewan's health system faces many of the challenges experienced by jurisdictions around the world: an aging population, increased chronic disease, unrelenting competition for health care workers, inadequate access, inconsistent quality, rising costs, and new, expensive technologies and treatments. The impact of these challenges is even greater when considered in the context of Saskatchewan's geography, with a population of just over one million people, widely dispersed communities, climate extremes, and significant health disparities between Aboriginal and non-Aboriginal citizens.

[Saskatchewan residents] clearly want value for this investment and assurance that their tax dollar is put to best use. The Patient First Review found room for improvement in this regard.

Saskatchewan has one of the oldest and, paradoxically, one of the youngest, populations in Canada. Baby boomers, who typically have high expectations of all service industries (and particularly the health system), are likely to be healthier in old age than past generations. Still, their numbers alone will create pressures on the system. From 2001 to 2008, about 14.5 per cent of the Saskatchewan population was over the age of 65 years. Statistics Canada estimates that nearly 25 per cent of Saskatchewan's population will be over the age of 65 by 2031. Government and health care leaders must look to the future and plan accordingly. For example, the system must prepare to respond to an increased need for joint replacements, home care and supports for self-managed care, and long-term care. The glaring disparity between the health of Aboriginal and non-Aboriginal citizens must also be addressed with urgency.

Escalating costs

The people of Saskatchewan continue to make significant investments in health care – $4 billion in 2009-10. Average per capita spending in Saskatchewan was $5,393 in 2008 and is above the national average of $5,170[1]. Since 1996, health care expenditures have grown an average seven per cent each year, which have consumed over 40 per cent of overall government program spending in Saskatchewan. Despite this increasing investment, unacceptable gaps in the quality and safety of health care persist.

While Saskatchewan residents who participated in the Patient First Review did not criticize increased spending on health care, they clearly want value for this investment and assurance that their tax dollar is put to best use. The Patient First Review found room for improvement in this regard.

Quality and efficiency issues

Saskatchewan patients deserve health care characterized by quality standards and leading clinical practices. Quality in health care is also seen in the training, knowledge, skills, attitudes and behaviours that care providers bring to their relationship with patients and colleagues. Continuous improvement in quality and safety is integral to a progressive workplace culture and is what patients expect from those who deliver health care.

Inadequate health care results in increased disease, illness and mortality. When the health care system fails to alleviate conditions that cause pain and disability, the results include a lower quality of life for individuals, a less productive workforce and unnecessary costs.

Many of the quality concerns expressed in our consultations with patients and providers are echoed by leading voices for quality health care in North America. For example:

Variation in services. Despite well-documented leading practices and well-established guidelines for many types of care, patients with the same health issues will often receive very different care, depending on where they live[2].

Underuse of services. Too many patients do not receive necessary care and, as a result, suffer needless complications that add to costs[3].

Notations: See Endnotes, page 56

Overuse of services. Too many patients receive services that are unnecessary, increase costs, and may even endanger their health[4].

Misuse of services. Too many patients are injured during the course of their treatment, and some die prematurely as a result. Approximately 16,000 people hospitalized in Canada in 2000 died from an adverse event[5]. In Saskatchewan, this translates to 300-600 avoidable deaths per year or at least one avoidable death each day.

Waste, redundancy, and ineffectiveness means increased cost to the patient … and increased risk of harm.

High quality does not necessarily mean high cost

It is possible to improve the quality of health care in Saskatchewan AND control health care's spiralling costs. In fact, best quality practice can, in many cases, result in savings to the system.

Other industries have long understood the costs of poor quality; when something isn't done right the first time, there are inevitable costs associated with repairing the damage that is done. In health care, this waste, redundancy, and ineffectiveness means increased cost to the patient (and to society), not to mention increased risk of harm from multiple unnecessary procedures, adverse effects of medication changes, infections from longer hospital stays, and progression of disease caused by delay in receiving the right care.

In a recent Commonwealth Fund report [6], Canada had the second-highest rate of health care spending among six countries – and yet ranked fifth in health care quality. The United States had the highest rate of health care spending and had the worst health outcomes of the six countries.

Spending and quality are not necessarily linked, which means that simply spending more is not the solution. The solutions are to be found in a better integrated network of services, populated by providers who are enabled to use all of their skills and training, who provide care in accordance with evidence-informed best practices, and who interact effectively with the patient and with each other.

Health care provider-oriented culture

Our current health care system has been designed around the people who deliver the care. It is time to realign the values of Saskatchewan's health system so that the patient is again made the centre of attention.

This does not necessarily imply a realigning or wholesale restructuring of the services themselves. In fact, the perpetual change agenda in health care, with its continuous restructuring and disruption, has eroded organizational loyalty and distracted individual care providers from a focus on the patient's interests.

It is time to realign the values of Saskatchewan's health system so that the patient is again made the centre of attention.

Changes to the health system must serve to meet patients' needs, and a publicly designed health system must reflect the values of the patients and citizenry, while enabling providers to do their work in a stable, safe, supportive, and collaborative environment.

As my researchers and I listened to patients, families, providers, and health-system leaders, we heard them describe significant inconsistencies in accessibility, quality, and patient focus within Saskatchewan's health system. Add to these concerns the issues of questionable value-for-money in some spending areas and ongoing financial sustainability challenges, and we heard a compelling case for change.

Health care leaders, including Ministry of Health officials, must reject the notion that the Saskatchewan health sector is too unique or constrained to adopt innovative and creative solutions seen in the broader public sector, other health jurisdictions and the corporate sector. Saskatchewan's demographics and geography have always made partnership and cooperation necessary to achieve meaningful and lasting improvement.

The Patient First Review

The term patient is used broadly and represents patients, clients, and residents who receive a variety of health services.

As demonstrated by the issues described above, Saskatchewan's health system is in need of change. Its current culture and structure do not equip it well for its current challenges, let alone the challenges that will arise and intensify in coming years.

In November 2008, the Minister of Health launched the independent Patient First Review of the Saskatchewan health system[7]. Within the parameters of this review, the term patient is used broadly and represents patients, clients, and residents who receive a variety of health services.

The review comprised two distinct streams of research: an examination of the patient experience across the full continuum of health care services; and the administration of health care in regional health authorities (health regions), the Saskatchewan Cancer Agency and the Saskatchewan Association of Health Organizations (SAHO). Focus groups were held with randomly selected patients and frontline health care providers, and consultations were held with selected health professionals and health care leaders throughout the province. This dialogue was supplemented with written and online submissions, a Commissioner's weblog, analysis of financial and statistical data, and consideration of leading practices and policy innovations in other jurisdictions.

While the methodology used for each research stream differed substantially, the findings and recommendations are integrally connected in this report. The administration of health care has a profound effect on the efficiency of service delivery and the quality of care that patients experience.

Profound structural change to the health system at this time would only serve to distract from what needs to be the immediate and first priority – restoring the patient to the centre of the system.

The diversity of Saskatchewan's population was reflected in the patient consultations, which included seniors and young people, and rural, northern, urban, First Nations, and Métis people, the prosperous and the disenfranchised. More details concerning the Patient First Review's methodology can be found in the research reports released with this report (see www.health.gov.sk.ca/patient-first-review).

The review process itself embodied a spirit of openness and transparency that should characterize how health care services are designed and delivered in the future. As the review proceeded, I have shared information with health care leaders, providers, stakeholders, and the public and have been encouraged by the response. Action is already underway to address some identified issues.

Given the mandate for this review, I have not examined or made any recommendations respecting changes to the existing regionalized model of governance. Profound structural change to the health system at this time would only serve to distract from what needs to be the immediate and first priority – restoring the patient to the centre of the system. This should not, however, deter the government from considering such changes in the future, and this report will include some ideas on how to streamline the integration and effectiveness of services for the benefit of patients and taxpayers alike.

Patients clearly value health care. They recounted positive experiences with the health system, and believe we should build on the system's strengths. They also expressed urgency about fixing longstanding issues of concern in the system. Frontline providers and system leaders affirmed what I heard from patients, and shared their own ideas for positive change.

While I have attempted in this report to reflect all of the significant themes that were encountered during the review's research, I do not pretend to have provided a "fix" for every concern that was expressed. Some of the health system's struggles are due to factors largely beyond Saskatchewan's control, such as a global shortage of certain categories of health care professionals, cost escalations, and growing demand for progressive health care.

I do not pretend to have provided a "fix" for every concern that was expressed.

6

Summary of Findings and Recommendations

Guiding principles:

- Patient First as a core value;
- Cohesive health care system; and
- Empower frontline providers.

After hearing from more than 4,000 Saskatchewan citizens and hundreds of health care providers and system leaders, the Patient First Review team received the clear message that Saskatchewan's health system is a good basic system, but needs serious and immediate remedy and rejuvenation in a number of areas. "Keep the best and fix the rest" could be the summary message. Following are three themes that emerged as guiding principles in my report's roadmap for change:

1. **"Patient First" must be embedded as a core value in health care** and ingrained in the "DNA" of all health care organizations. The health system has lost its focus on the patient and lost sight of the fact that health care is a service industry. The best interests of patients and families must be the primary driver of policy decisions, collective agreements, priority setting and resource allocation decisions, and the operation of workplaces. Keeping the patient voice alive after this review has been concluded will assist in maintaining focus and ensuring that other factors do not override patient and family needs.
2. **Health care in Saskatchewan needs to function as a cohesive system.** Only a well-integrated system can respond to patients as whole people rather than parts that need fixing. Health care has been

compromised by a piecemeal approach that has failed to recognize the interconnectedness between one part of health care and others. This fractured mode of operation manifests itself at the care-giving level, where team-based, interdisciplinary care remains the exception rather than the rule. Care is delivered in silos, and new care models are resisted by providers guarding their own interests – to the detriment of patients. There is also a lack of coordination and standardization within the health system's administrative and leadership structures. The health system needs to operate as one virtual entity with consistent policies that have one primary objective: to put the patient first.

3. **Frontline providers must be empowered to deliver patient- and family-centred care.** Health care providers consulted during the course of this review consistently affirmed and echoed patients' pleas for a more patient- and family-centred system. Unfortunately, poor communication and ineffective relations between providers and health system management have often prevented both parties from instituting positive change. Effective leadership and improved system performance are critical to supporting that care model.

If Saskatchewan's health system is to become truly patient- and family-centred, progress must be made on all aspects of care planning and delivery.

My report is divided into two sections, in keeping with the two research streams that comprised the Patient First Review. The first group of recommendations concerns the experiences of patients and families and is based upon specific elements of patient- and family-centred health care. The second section builds on the findings of the health care administration review and contains recommendations for administrative and leadership structures that will support Patient First as the driving philosophy in Saskatchewan health care. Supporting facts and details for each recommendation, along with additional observations and 'possible pathways' to implementing more patient- and family-centred care, are included in the main body of my report.

It is important to note that the order in which these findings and recommendations are presented does not imply any particular order of importance or priority. If Saskatchewan's health care system is to become truly patient- and family-centred, progress must be made on all aspects of care planning and delivery. Progress in one area will have a natural impact on others.

Some of my recommendations are addressed to specific groups or organizations – the Ministry of Health or health regions, for example. Many, however, are a call to action for the health system as a whole, which would encompass the above organizations as well as affiliates and health care organizations, and other health care provider agencies.

This report's findings are addressed to all of the health system's leaders — clinical and non-clinical, political and professional, patient advocacy groups, labour organizations — all those individuals who, by virtue of their roles within the system, can contribute to developing more patient- and family-centred health programs and services. In fact, I believe every single care provider and manager, every policy-maker and leader, no matter what their formal title or job description, has an opportunity to respond in some way to Saskatchewan patients' voices as expressed through my report. Strong, focused leadership will be essential in translating those voices into lasting change. Equally critical, however, will be those changes introduced at the service level by proactive care providers who are passionate about patient- and family-centred care.

Many [of my recommendations] are a call to action for the health system as a whole ... Every single care provider and manager, every policy-maker and leader, no matter what their formal title or job description, has an opportunity to respond in some way to Saskatchewan patients' voices ...

Finally, the work of the Patient First Review has produced more recommendations and possibilities for positive change than are found in my report alone. Researchers and analysts with KPMG and Deloitte have produced reports of their own containing numerous recommendations based on discussion with patients, families, care providers and system leaders. Many of these recommendations are incremental and/or operational in nature, as they should be. The recommendations contained here in my report are, I believe, most fundamental to achieving a truly patient- and family-centred health system.

These are the transformative changes that make other changes possible and which will bring about progressive change.

Commissioner's Recommendations

I. Improving the Patient Experience

For a patient- and family-centred health system:

1. That the health system make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system wide. Developed in collaboration with patients, families, providers and health system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all workplaces.

For equitable care:

2. That the health system develop a comprehensive and innovative strategy for rural and remote service delivery that:
    - a) Improves access to primary health, diagnostic and specialist services for rural and remote residents;
    - b) Examines the cost burden of emergency transportation, including interfacility transfers; and
    - c) Includes a range of supports for people who must obtain health services away from their home communities.
3. That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:
    - a) System capacity to support independent living;
    - b) Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;
    - c) Accessibility and quality of assisted living and long-term care;
    - d) Programming for seniors with extraordinary behaviours that cannot be safely managed in the general long-term care population (e.g. specialized assessment and treatment units); and
    - e) Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs, and a specialized outpatient clinic.

4. That health regions, the Cancer Agency and other health care organizations work with First Nations and Métis organizations, Elders, and patients to develop partnerships aimed at improving the health of First Nations and Métis people. This joint work may include but not be limited to:

   a) Assisting First Nations and Métis patients to navigate the health system and advocating for better care;

   b) Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;

   c) Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services;

   d) Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;

   e) Addressing health system gaps as identified by the Memorandum of Understanding on First Nations' Health and Well-Being Steering Committee and the renewed partnership with the Métis Nation - Saskatchewan; and

   f) Encouraging First Nations and Métis organizations to partner in the provision of health care services that will directly benefit their communities.

For coordinated care:

5. That the health system develop a more integrated and inter-sectoral approach to services for children and youth.

6. That the Cancer Agency and health regions improve the coordination and integration of cancer care services across the continuum of cancer care.

For convenient, timely care:

7. That the health system take immediate action to improve Saskatchewan patients' surgical experiences, from initial diagnosis through to recovery, through an aggressive, multi-year, system-wide strategy that is reported to the public with clear targets and regular updates.

8. That the health system address inappropriate usage of emergency rooms by exploring the applicability of urban urgent care centres. The appropriate health regions should explore alternate financing partnerships in developing these projects, which should incorporate state of the art design and leading technologies.

For communicative, informative care:

9. That the Ministry of Health, in collaboration with health regions, the Cancer Agency, provider organizations, and patient and family advisors, develop and implement a Charter of Patient Rights and Responsibilities.

For comprehensive care:

10. That the Saskatchewan government and health system pursue an aggressive and targeted emphasis on the promotion of good health and the prevention of illness and injury in Saskatchewan. Not only will this pay dividends in a healthier and more productive populace, it will help to ensure that Saskatchewan's health system is ready and able to help all of us when we need it most.

11. That the health system develop and implement a province-wide chronic disease management strategy that ensures patients receive evidence-based, standardized care, wherever they live, and connects patients with multidisciplinary health care teams.

For respectful care:

12. That the health system, in collaboration with First Nations and Métis Elders, and patient and family advisors, work to develop a culturally safe and competent health system that better serves First Nation and Métis citizens.

For functional e-health care:

13. That the Ministry of Health, in consultation with the health regions, the Cancer Agency, and clinical leaders, invest in and accelerate development of provincial information technology (IT) capabilities within a provincial framework. This will involve:

    a) Developing an eHealth implementation plan by early 2010;

    b) Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and

    c) Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.

II. Improving System Performance and Leadership

14. That the Ministry of Health achieve greater value for patients' tax dollars by establishing a provincial shared-services organization that would gain buying power and realize significant savings. This organization would initially be responsible for supply chain management (competitive tendering, procurement, storing, distribution, and payment), with the subsequent addition of responsibility for health regions' transactional business functions.

15. That the Saskatchewan government explore ways and means to develop a coherent financing plan, including alternate financing partnerships, to address the urgent need for capital infrastructure investment.

16. That the Ministry of Health move forward with organizational changes that will enable it to assume more of a strategist-integrator-steward role for the health system.

I. Improving the Patient Experience

1. A Patient- and Family-centred Health System

> *"It's easier to go home and risk losing your leg or your foot than be hassled at the very place that is supposed to help you."*
> *(Patient)*

> *"...we have built a system around clinicians that makes it impossible to customize care the way it needs to be. We don't have a standard of services or processes that are comfortable for patients. We have built a technocratic castle, and when people come into it, they are intimidated."*
> *(Donald Berwick, President/CEO, Institute for Healthcare Improvement)*

Patient- and family-centred health care considers the patient's needs and interests first and foremost. Patients who shared their stories and perspectives want their needs, values, culture and spirituality respected. They want support during times of illness and trauma, and effective, compassionate communication that can help to relieve fear and anxiety. They want complete information about care and treatment options.

Saskatchewan people want their health care to be of high quality, safe, readily accessible and timely, with well-coordinated, seamless and reliable transitions between health care sectors and regions. Patients want support to navigate the system and responsive avenues for recourse when treatment concerns arise.

Saskatchewan people want their health care to be of high quality, safe, readily accessible and timely, with well-coordinated, seamless and reliable transitions between health care sectors and regions.

We know that `Patient First' will be a reality in Saskatchewan when a patient, hurriedly preparing to leave his family doctor's treatment room, hears the physician say, "We still have some time. Is there anything else you'd like to talk about?"

This will require a new culture within the health system: a culture of listening to patients, sharing decisions at an individual care and policy level, and evaluating those decisions based on how they affect the patient.

Patient- and family-centered care is grounded in mutually beneficial partnerships among health care patients, families, and providers. Patient- and family-centered care applies to patients of all ages, cultures and socioeconomic backgrounds and recognizes their unique social, emotional, spiritual and cultural needs. This becomes particularly important for First Nations and Métis people and for new Canadians requiring health care services.

Fundamental to achieving patient- and family-centred care is patient-centred governance and policy-setting, beginning with the Ministry of Health and supported by unified, prudently managed, high-performing health care administration that enables, empowers and expects everyone to put the patient first.

As health care systems around the world wrestle with the concept of "patient- and family-centred care", there have been numerous attempts to define the term. After all, most health care systems comprise hundreds or thousands of care providers serving thousands or hundreds of thousands of people, and it becomes important in an enterprise of such magnitude to have a clear picture of the organization's goals.

How do we know when we've achieved patient- and family-centred care? How do we know when `Patient First' has become the way of doing business in Saskatchewan's health system? What does it look like?

Based on the thousands of interactions my researchers and I had with Saskatchewan people, it is possible to provide a number of brief sketches or snapshots of what Patient First can look like in the province that gave our nation Medicare.

Taken together, I believe these brief portraits comprise a compelling vision of excellence – of a health system that puts its patients first, and in doing so, also becomes an endlessly rewarding career base for thousands of care providers.

We know that `Patient First' will be a reality in Saskatchewan when:

- **A patient,** hurriedly preparing to leave his family doctor's treatment room, hears the physician say, "We still have some time. Is there anything else you'd like to talk about?"
- **A patient needing a hip replacement** is referred to a group of surgeons who work as partners; while this means a shorter wait for the procedure, the patient still has the option of choosing a surgeon.
- **The farmer needing to travel** to Regina to see a specialist, physiotherapist and orthotist is able to see them all on the same day – or even in the same clinic room;
- **Signs in workplaces** that say "ABUSE WILL NOT BE TOLERATED" are replaced by signs saying, "We promise to treat you with compassion and respect. We ask that you do the same."

- **A senior with complex health issues**, who spends much of his day surrounded by care providers, can know their first names by reading them on their name-tags. The providers, meanwhile, also know their patient's name and work as a team to meet his needs.
- **An elderly Dene man** in a northern community, about to be placed on an ambulance for medical transport to Saskatoon, is encouraged to bring his English-speaking daughter with him.
- **A 40-year-old woman** recently diagnosed with Type II diabetes gets a surprise call from her dietitian, who asks, "How are you doing with your new meal plan? Are you finding it difficult? Any questions?"
- **A single mother** whose youngest son requires regular blood testing receives an email notification that he is due for his next test. When she appears at the lab, the test is completed promptly. Three days later, she is able to access the result on a confidential website and compare it to previous results.
- **Every one of the patients** in the emergency room on a busy Saturday night knows roughly how long they will need to wait, and why.

These are only a few examples of what can happen in a health system when the system serves the patient, rather than the other way around. Imagine this kind of patient- and family-centred care as the norm in Saskatchewan. Imagine the satisfaction and pride that would follow among patients and their families, and also among Saskatchewan's valued health care workers.

These scenarios help to illustrate a number of the elements of patient- and family-centred care that I wish to emphasize in my report and recommendations. A health system that is characterized by the following qualities is one that would be the pride of its citizens and serve as a model for other jurisdictions around the world.

Without making any claims to a comprehensive or exhaustive definition of patient- and family-centred care, we can say that it is characterized by:

- **Equitable care.** Patients receive the amount of care they need when they need it, regardless of where they live, their age or ethnicity, or other factors.
- **Coordinated care.** Whether working in the same unit or across multiple programs, disciplines and sites, providers are working together to meet the patient's evolving health care needs and help the patient and their family to navigate the system. Effective care coordination can also improve continuity and stability by reducing the number of providers a patient must interact with on his or her care journey.
- **Timely and convenient care.** Patients can access the care they need without waits that prolong pain or debilitation, or barriers that introduce prohibitive expense or difficulty. Intervals between needed services are short, and the need to travel to different locations is minimized.
- **Informative care.** Patients are always well informed about their health and the factors affecting it, treatment options, and the "5 W's" of their next care steps (Who? What? When? Where? Why?). Providers take the time to explain, to clarify, and perhaps most importantly, to listen to patients and their families.

- **Comprehensive care.** Health care providers are attuned to all, not just some, of a patient's needs, and are equipped and empowered to deliver holistic care that respects the complexity and interrelation of physical, psychological, spiritual, and socioeconomic factors. Patients and families are given the time to express their needs.
- **Respectful care.** Patients are treated with empathy and understanding for their fears and hopes. The relationship between patient, family and provider is a balanced, mutually respectful partnership, not an imbalanced power dynamic that favours the provider.
- **Functional e-health care.** Patients only need to provide information once, after which it becomes accessible to those who need it to deliver care. Patients have ease of access to their health records and the opportunity to add relevant information.

The entire health system must share a common patient- and family-centred vision and direction and systematically implement actions to achieve this vision.

This is the kind of health system that Saskatchewan patients have told me they want to see. Wherever their experiences with the system have failed to meet their expectations, it was due to inconsistency or outright failure in at least one of these elements of patient- and family-centred care.

Taken as a whole, these elements comprise nothing less than a significant shift in Saskatchewan's health care culture. While the vast majority of health care providers want to deliver patient- and family-centred care, they are too often constrained, discouraged or disabled by a system that encourages them, implicitly and explicitly, to put other interests ahead of patient interests.

The entire health system must share a common patient- and family-centred vision and direction and systematically implement actions to achieve this vision. "Patient First" cannot be a mere lapel pin, button, or logo; it must be a way of doing business for all those associated with health care, regardless of their role, title, or tenure.

This leads to my first recommendation, which forms the foundation for all of the recommendations that follow:

Commissioner's Recommendation

1. **That the health system make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system-wide. Developed with patients, families, providers and health-system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all work places.**

Throughout the report, I have included "possible pathways" for consideration as a mechanism to help achieve the recommendations.

Patient First possible pathway: The Patient First philosophy could also be applied to Saskatchewan's health care labour relations model, an obsolete, adversarial, industrial relations approach that currently exiles patients from the process as employers and employees bargain from positions of strict self-interest. A new, collaborative approach could restore patient interests to the process.

Customer-owners

A patient's relationship with the health system is more complex and profound in its impact than a typical "customer" relationship. In the absence of any "competition" to publicly funded and administered health care, the system's leaders and providers may be less aggressive in pursuing excellence in the face of numerous pressures. Nonetheless, Saskatchewan citizens do fund their health system, and the concept of good customer service is therefore applicable.

"Patient First" cannot be a mere lapel pin, button, or logo; it must be a way of doing business...

Current funding models serve as a barrier to those providers who are keenly interested in providing patient- and family-centred care.

The Southcentral Foundation (SCF), a non-profit health system serving approximately 50,000 Native and American Indian people in Alaska, acknowledges that patients in the system are not only "customers," but "owners" as well. SCF refers to its patients as "customer-owners" and uses multiple methods for hearing the customer-owner's voice, including personal interaction with staff, satisfaction surveys, an annual "Listening Conference" and a formal complaint process.

While physicians and clinical teams provide expertise, keep track of preventive matters, explain options and make recommendations, the customer-owner is in control and ultimately makes the decisions[8].

Patient First possible pathway: Patient- and family-centred care utilizes patient and family advisors to bring about positive change in hospital units, in developing and revising health programs and services, in strategic planning and in evaluation of all of these activities. Advisors may be identified when they express an interest in serving in this way or through recommendations from health care providers and administrators. These advisors, who would undergo a selection screening process, typically have had recent interaction with a particular service or program and genuinely want to work with staff and providers to improve the system.

2. Equitable Care

What it looks like: ***Patients receive the amount of care they need when they need it, regardless of where they live, their age or ethnicity, or other factors.***

A strategy for rural and remote communities

Concerns about inequities between urban and rural or remote communities were continuously voiced. Generally, people expect to travel to larger centres to see specialists or to have complex surgeries. Stories were told of patients travelling three to four hours by bus or medical taxi and returning home the same day, of children who go without occupational therapy because their family cannot afford to travel two hours, and of mothers who have to leave their families four to six weeks before their due date to go "south" to have their babies.

> *"In our small community, we have three patients who need dialysis three times a week. The nearest town has a satellite dialysis unit, but it is full. Our three patients leave home at 6:00 or 6:30 in the morning, travel over a long bumpy section of gravel highway, which is really hard on the body, and arrive in Saskatoon at about noon. When they are finished their treatments around 5:00 p.m., we stop to have some supper. Then we head home and get back to our community around 11:30 p.m. or midnight."*
> *(Medical taxi driver)*

More needs to be done to ensure equity and fairness in the health system, including the development of a comprehensive plan for rural and remote service delivery...

These are examples of basic health needs that the system must plan to meet closer to home for the sake of patients. I also urge urban regions to coordinate patient appointments and tests in order to avoid multiple long-distance journeys for patients.

More needs to be done to ensure equity and fairness in the health system, including the development of a comprehensive plan for rural and remote service delivery which can be informed by this report. In addition, the Regina and Saskatoon health regions, with their prevalence of specialists, should show leadership by providing more clinics in rural and remote areas outside Regina and Saskatoon. Residents of rural and remote communities would then be spared long-distance travel for what are often brief appointments.

Urban health regions should coordinate mobile diagnostic resources that would eliminate travel to Regina and Saskatoon.

[illegible]

2. **That the health system develop a comprehensive and innovative strategy for rural and remote service delivery that:**
   - **a) Improves access to primary health, diagnostic and specialist services for rural and remote residents;**
   - **b) Examines the cost burden of emergency transportation, including interfacility transfers; and**
   - **c) Includes a range of supports for people who must obtain health services away from their home communities.**

Saskatchewan's growing seniors population ... will need a broader range of health care and affordable living options ... from supported independence to institutional care.

Patient First possible pathway: Though not new, telehealth technology can improve access to health care services and help disseminate knowledge. Over time, providers have become more adept at the use of technology, and patients, especially those familiar with distance technology, appreciate the convenience. Telehealth also offers increased access to learning tools, such as the opportunity to participate in "clinical rounds" and training. Other emerging technologies, such as telemonitoring, provide patients with immediate feedback on health indicators such as blood pressure, and guidance to self-manage their care.

Equitable care for seniors

Saskatchewan's growing seniors population is projected to nearly double to 25% by 2031. In addition, life expectancy is projected to increase to 81.1 years for men and 85.9 years for women by 2031[v]. This will necessitate a broader range of health care and affordable living options for older people, from supported independence to institutional care. Patients, frontline providers and stakeholders all indicate that the health system is challenged to match resources to the level of care and support required by individual seniors. The consequences for seniors living alone in their home with few supports can include social isolation, poor nutrition and worsening health.

Seniors needing long-term care are ill-served by a system that leaves them in hospital beds, without the requisite supports and programming, while awaiting placement in an appropriate facility. The financial, physical and emotional costs can be significant, and at times overwhelming, for the individual, their spouse and family.

Families told stories of long waits to get into special-care homes and parents who were separated after 55 years of marriage, often in different towns...

> *"Adult Day Centre spaces are crucial to the well-being of the adult with dementia or other people with high care needs and provide much needed respite to the family caregivers."*
> *(Health care provider)*

Families told stories of long waits to get into special-care homes and parents who were separated after 55 years of marriage, often in different towns, because their care needs could not be met at the same care homes.

> *"In order for my parents to stay together, they had to purchase service from the private sector. The cost of this for two people, one level 4, the other level 2, was over $60,000 per year."*
> *(Patient's family member)*

> *"There were no beds in the long term care facility in the community my mother-in-law lived in, so she had to be put in a nursing home in a neighbouring town – it was really hard for her – she had roots in her town."*
> *(Patient's family member)*

Concerns about care for seniors formed a consistent theme in all of the patient-experience focus groups, with many participants sharing stories about less-than-ideal quality of care. Some were concerned about a lack of attentiveness to long-term care residents' needs. This manifested itself in such issues as infrequent bathing, or seniors being left in their beds with very little social interaction and few opportunities to move and exercise their joints and muscles. Some families spoke of expensive medications, or said they lacked confidence that medications were being administered properly or safely. Others felt that institutional scheduling practices were of more benefit to staff than to residents.

Despite modest increases in resources for home care, demand exceeds availability, leaving people to rely on informal caregivers such as an aging spouse, children, and other relatives and friends.

> *"In facilities, family members should have input on the types of activities their elderly family members could participate in and also in the choice of their diets."*
> *(Patient's family member)*

After hearing patients and their families recount their negative experiences, I suggest that the Saskatchewan model of assisted living be expanded for the elderly in Saskatchewan. This model would fill the current gap between home care and personal care homes or long-term care. It should be designed to promote a philosophy of service for those elderly citizens who need flexibility in the menu of services and programs they may require as they age. Designed with a home-like environment, such facilities can offer more independence for residents. In principle, the cost to the patient should be less than long-term care covered by government policies. If designed properly, assisted living can reduce the expected future demand for services for the aging population.

To live in their own home, many seniors rely on home care for regular supportive care and nursing or other professional services intermittently. Despite modest increases in resources for home care, demand exceeds availability, leaving people to rely on informal caregivers such as an aging spouse, children and other relatives, and friends. Home care, when it works well and is responsive, will allow Saskatchewan residents to age at home and maintain good health and relative independence. This will pay huge dividends in easing the pressure on hospital beds, emergency rooms, and long-term care institutions.

> *"My 74 year old brother with dementia is being looked after by my 74 year old cousin because the district can't accommodate him. He only has his old age pension and security so he can't afford private care. Luckily our cousin is kindhearted and willing to look after him. But she is of the age that soon she won't be able to and then what?" (Patient's family member)*

The provincial government has appointed a Legislative Secretary for Surgical Wait Times and Long-Term Care. This indicates both an acknowledgement of and commitment to seniors' issues. The province is also developing a Seniors' Strategy, which will include a full and focused review with comprehensive recommendations. The findings and recommendations within this report should inform this broader strategy development.

3. **That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:**
    - **a) System capacity to support independent living;**
    - **b) Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;**
    - **c) Accessibility and quality of assisted living and long-term care;**
    - **d) Programming for seniors with extraordinary behaviours that cannot be safely managed in the general long-term care population (e.g. specialized assessment and treatment units); and**
    - **e) Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs, and a specialized outpatient clinic.**

Equitable care for First Nations and Métis people

The health and well-being of First Nations and Métis citizens in Saskatchewan is influenced by culture, shifting demographics, geography, increasing population and the challenge of blending contemporary medicine with traditional healing.

My researchers and I took steps to ensure that the First Nations and Métis voice was heard during this review. In all of the general-population focus groups, at least one First Nations person and one Métis person were invited to attend. Four additional focus groups were held for First Nations and Métis people exclusively, in urban, rural and northern locations. Focus groups were also held on three reserves. Registered nurses working on reserve were invited to attend the provider focus groups and the Federation of Saskatchewan Indian Nations (FSIN), the Métis Nation - Saskatchewan (MN-S) and the Northern Inter-Tribal Health Authority were invited to attend the stakeholder forums. We decided that a minimum of 15 per cent of individuals we spoke to through our telephone survey should be self-identified as First Nations and Métis. I also attended meetings of the FSIN Health and Social Development Commission, the MN-S Health Roundtable and the Memorandum of Understanding on First Nations Health and Well Being Steering Committee. Through all of these mechanisms, we were able to distinguish the First Nations and Métis patient experience from the rest of the population.

My researchers and I took steps to ensure that the First Nations and Métis voice was heard during this review.

The number of First Nations and Métis people living in Saskatchewan is growing faster than the number of non-Aboriginal people and they currently comprise about 15 per cent of the provincial population, projected to increase to 21 per cent by 2017. With this faster growth rate, it's not surprising that Saskatchewan has the youngest Aboriginal population in Canada, with a median age of 22. In 2001, 25.9 per cent of the total Saskatchewan population aged 0-14 years was First Nations or Métis. This is projected to increase to 36.6 per cent by 2017[iii]. These two groups of people typically experience lower health status than other Saskatchewan people. For example, First Nations and Métis people have significantly higher incidences of diabetes, tuberculosis, cardiovascular disease, obesity, arthritis and rheumatism. This disparity in health status is frequently attributed in large part to socio-economic disadvantages.

First Nations and Métis people have significantly higher incidences of diabetes, tuberculosis, cardiovascular disease, obesity, arthritis and rheumatism.

During our consultations, we heard stories of hardship associated with obtaining health care. Some people spoke of having to choose between buying groceries or their medications, while others related the need to hitchhike from their small communities to larger centres to get chemotherapy or dialysis treatments because they didn't have the money for appropriate transportation. Métis people residing in fly-in communities told of how they are making health care decisions based on whether or not they can pay for multiple, subsequent flights in and out of their community to receive the prescribed treatment.

4. That health regions, the Cancer Agency and other health care organizations work with First Nations and Métis organizations, Elders, and patients to develop partnerships aimed at improving the health of First Nations and Métis people. This joint work may include but not be limited to:

- **a) Assisting First Nations and Métis patients to navigate the health system and advocating for better care;**
- **b) Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;**
- **c) Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services.**
- **d) Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;**
- **e) Addressing health system gaps as identified by the Memorandum of Understanding on First Nations' Health and Well Being Steering Committee and the renewed partnership with the Métis Nation - Saskatchewan; and**
- **f) Encouraging First Nations and Métis organizations to partner in the provision of health care services that will directly benefit their communities.**

Equitable care for patients and families with mental health issues

> *"When I really needed the help there was no one available. I had to wait for six weeks. Then when we finally got in, the one I was seeing was changing jobs so I had to wait again. So I said, 'Forget it!'"*
> *(Patient)*

Due to the ongoing social stigma connected with mental illness, patients and their family members are often reluctant to speak up about quality and access concerns. Yet mental health continues to be a significant health issue for a large portion of the population, and the lack of attention to it brings untold costs to society.

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Most of Saskatchewan's psychiatrists are based in the province's urban centres and practice without any province-wide system for accepting referrals. Mental health referrals should be organized on a provincial level so that access to psychiatrists is equitable for all Saskatchewan residents, regardless of where they live.

> *"The only way to get to see a psychiatrist here is to threaten to commit suicide."*
> *(Patient)*

With a limited number of psychiatrists distributed unevenly throughout the province, family physicians — with limited training in managing mental health issues — become the default option for many patients needing mental health care. Health system leaders need to examine whether the most effective use is being made, not only of psychiatrists' time and skills, but of the entire range of mental health professionals.

> *"Family physicians are treating over 75 per cent of mental health disorders – and almost every family has been touched by that. Providers need education about seeing this as a 'normal' health problem that can and should be dealt with in a normal way."*
> *(Health care provider)*

> *"We moved here from Ontario where we had an excellent family doctor and a wonderful cognitive psychologist to provide excellent medical care. When we asked our first family doctor here about a cognitive psychologist, he replied 'A what?' This does not inspire confidence."*
> *(Patient's family member)*

Mental health care for children and youth is extremely important, and has been the subject of other reports. I received input that the waiting list in some places for services is still between eight months and one year for children who are in urgent need of those services, which places tremendous pressure on both families and the school system.

Appropriate suicide education and prevention programs should also be available across the province, but especially in the education system.

> *"If you are depressed or injured, the system will dismiss you as an attention seeker—they think you are faking. They take you seriously when they find your body."*
> *(Patient)*

Finally, I also received considerable input from families with children diagnosed with autism. These individuals spoke passionately about the need for early diagnosis and treatment and the limited availability of autism care in Saskatchewan as compared to other jurisdictions.

> *"There is no coordinated autism service in this province and that is a huge negative to our health system. There is also a waiting list for services with over 200 children on it and this is unacceptable. Early intervention is the key in this disorder and the early intervention dollars spent now will be miniscule compared to the long term costs the government will face when these children become adults."*
> *(Patient's family member)*

> *"It took almost three years for my son to be assessed for pervasive development disorder."*
> *(Patient's family member)*

A strategic plan, based on review of the current resourcing and configuration of mental health services, would help to pave the way for a more patient-centred network of services.

I heard considerable comment on the emergency experience for mental health patients. People with chronic mental health issues deserve to have their concerns taken seriously when they present at the emergency room. The employment of members of the psychiatric care team in emergency

Mental health referrals should be organized on a provincial level so that access to psychiatrists is equitable for all Saskatchewan residents, regardless of where they live.

departments may speed intervention times for mental health patients. Many expressed the need for improved access to those services. A number of patients also called for 24-hour support for mental health crises.

> *"I have accessed the mental health system for treatment of my son. The response was poor. I have accessed the ER on two occasions. Once because he was suicidal. We were sent home. Within two weeks we had to commit him to access treatment. Again, a year later, the experience was no better. He was considered an emergency with an appointment three weeks down the road. Somehow we have kept him alive in spite of the lack of support he received. Mental health services need 24-hour response to crisis."*
> *(Patient's family member)*

Patient First possible pathway: Regina and Saskatoon should explore the feasibility of 24/7 service for people experiencing a mental health crisis. Services could include medical and mental health screening and assessment, crisis intervention and initial treatment services, and psychiatric consultation. This may ease pressure on emergency departments.

3. Coordinated Care

What it looks like: ***Whether working in the same unit or across multiple programs, disciplines and sites, providers are working together to meet the patient's evolving health care needs and help the patient and their family to navigate the system. Effective care coordination can also improve continuity and stability by reducing the number of providers a patient must interact with on his or her care journey.***

Help in navigating the system

Patients and their families are often anxious and frequently feel "lost" in the system. Lack of information and unfamiliarity with the health system are a great source of patient anxiety and dissatisfaction. We repeatedly heard about the need for assistance and basic information, direction, and referral information.

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> *"It can be very difficult when you are sick to take control of all of your appointments and what you need to do, especially if you are not used to it. You need someone to help you."*
> *(Patient)*

> *"There is so much lack of communication between the system and the regular Joe Blow out there, it is incredible. To try and find the appropriate person in whatever department, at whichever hospital at whatever level is an absolute nightmare."*
> *(Patient)*

Our researchers heard about the many navigation issues experienced by First Nations and Métis people, and also about their positive experiences when Elders were engaged to assist health care providers.

In a truly patient- and family centred health system, patient navigators would not be necessary. It would be the job of every health care professional, provider and support person to be attuned to patient needs and ensure patients are equipped with the information they need to continue their care journey.

Patient First possible pathway: There is opportunity within every Saskatchewan health region and the Cancer Agency to develop a variety of information and support mechanisms to help patients access and navigate programs and services. Some health systems have introduced a user guide for patients to equip them with essential knowledge about interacting with the health system.

Coordinating services for children and youth

Shortfalls in care coordination were particularly prominent in the narratives of parents sharing their experiences accessing health care services for their children. Many said emergency needs were generally well met, but noted significant gaps in service and supports for children with life-long needs resulting from physical, intellectual, and cognitive disabilities, mental illness, and chronic conditions such as obesity and diabetes. While gaps were identified in urban centres, they were magnified for children and families in rural, northern and remote communities.

> *"We had excellent care in the critical care ward, but felt completely on our own when transferred to the ward, and even more alone when discharged home."*
> *(Patient's family member)*

> *"The waiting list for specialists is too long. One and a half years for a child psychiatrist, 12 months for a speech language pathologist or occupational therapist. The window of opportunity to help these children and families is very small, and too often spent on a waiting list."*
> *(Health care provider)*

> *"We are bound within our health region. If your child has a severe physical condition, they will send them to one of the big hospitals for pediatric care. But if your child's problem is more of a mental disorder, you will have to stay within your own region because there are general mental health services around. This means that there have been times when my child had to be hospitalized with adults with mental health problems and this can be scary for him."*
> *(Patient's family member)*

> *"Children with mild to moderate needs can often improve the most from rehab services. However, these kids are receiving few resources as more kids with high needs are presenting."*
> *(Health care provider)*

Families identified financial, emotional, and physical burdens and their spinoff effects. Supports and services are available through many agencies such as health regions, school divisions, social services, and federal agencies, but they are not coordinated, and it seems to be up to the families to determine how to access services. This is in addition to the burden of care they carry on a daily basis, often in addition to other family and work-related responsibilities.

Supports and services are available through many agencies such as health regions, school divisions, social services, and federal agencies, but they are not coordinated, and it seems to be up to the families to determine how to access services.

> *"There is very little communication between the government departments. It seems each is more interested in protecting its boundaries than helping families."*
> *(Patient's family member)*

> *"The health system and the school system pass the buck between each other in terms of who should provide the services such as speech language pathology or occupational therapy."*
> *(Patient's family member)*

Commissioner's Recommendation

5. **That the health system develop a more integrated and inter-sectoral approach to services for children and youth.**

Coordinated care for patients with addiction issues

Individuals with co-occurring addictions and mental health conditions, in addition to other health concerns, require specialized, coordinated services that meet their specific needs. To provide a comprehensive continuum of care, service providers must collaborate effectively with other supports, particularly mental health programs.

Coordinated care for patients with cancer and their families

Over time, the convergence of increased service demands, workforce shortages, and the inability to keep abreast of enabling treatment technologies has challenged the Cancer Agency.

Long clinic waits, limited community supports and delayed treatments are all signs of poor integration and coordination. Many people spoke of appointments not being coordinated and described communication gaps between clinical staff, health regions and the Cancer Agency. There is pressing need to work toward an integrated health record between the Cancer Agency and health regions.

Patients and families reported generally that cancer care itself was good. However, a number of them also recalled incidents of disrespectful, unkind behaviours on the part of some providers. Some patients and system leaders also called my attention to instances of ineffective, strained relationships among clinical staff, management and health regions. Patients and families dealing with cancer should not have the additional worries of disjointed care and dysfunctional professional relations among those coordinating and delivering their care.

Patients and families dealing with cancer should not have the additional worries of disjointed care and dysfunctional professional relations among those coordinating and delivering their care.

The recently formed Saskatchewan Oncology Collaborative, with membership from the Cancer Agency, health regions, and Ministry of Health, is positioned to address some of these challenges.

> *"I was diagnosed with a rare form of cancer. Passed around to several doctors, surgeons and oncologists. Then referred out of province. It felt like no one was responsible for my care. Follow-up would be recommended, but no one knew who was in charge of my care. So it was never done. I found this out by getting a copy of my chart to ensure that I receive the appropriate follow-up.*
>
> *I feel like the only one looking out for my care is me, however, the health system is not user-friendly for patients. For example, obtaining copies of my notes or radiology films usually involved several visits, signatures and sometimes requires me to get other health care people to request on my behalf. One department's release of information policies would be different than the rest. In my situation, I was going through the system on an urgent basis and did not have the time, energy or knowledge to be looking after my own care. There was also a lack of communication between facilities, departments, specialists, hospitals that made my care not very consistent."*
> *(Patient)*

> *"...back to her family doctor, more pills. Then one night the pain was so bad she went to the hospital. She got to see an oncologist, did some tests and was sent home. Went to the oncologist office and was told about the cancer. But was told if it was found a few months earlier it could have been taken care of. Often she has appointments with different specialists and has to make numerous trips. Why can't there be some coordination to reduce trips?"*
> *(Patient's family member)*

The case study "Matthew's Story" (available for reference at www.health.gov.sk.ca/patient-first-review) highlights the challenges a child with cancer and his family faced during their care journey. It also illustrates that when a health system pays attention to the patient, the care experience can be dramatically improved.

Patient voices, validated by health care provider views, point to the need to improve the delivery of cancer services in the province. If the Cancer Agency is to meet its core obligation to citizens, cancer services need to be more effectively coordinated with health region service plans. To be successful, this process must start with dedicated and effective leadership at the governance level.

The opportunity exists to develop an action plan that speaks to ways of involving medical, clinical, and support staff to improve coordination of service and repatriate the 'caring spirit' that patients are longing for as users of the system.

An operational review of the Saskatchewan Cancer Agency, conducted in 2006, highlighted areas for improvement. For whatever reason, there is minimal evidence that progress has been made to address issues that affect the patients and the workforce. For example, a great deal can be done to standardize care in the Regina and Saskatoon clinics by adopting leading treatment protocols and care maps from other jurisdictions.

A great deal can be done to standardize care in the Regina and Saskatoon clinics by adopting leading treatment protocols and care maps from other jurisdictions.

Commissioner's Recommendation

6. **That the Cancer Agency and health regions improve the coordination and integration of cancer care services across the continuum of cancer care.**

Access issues are complex, and service gaps or delays in one area of health care create backlogs and bottlenecks in another.

4. Convenient, Timely Care

What it looks like: ***Patients can access the care they need without waits that prolong pain or debilitation, or barriers that introduce prohibitive expense or difficulty. Intervals between needed services are short, and the need to travel to different locations is minimized.***

Concerns about timely access to health care were voiced time and again by the majority of patients, providers and stakeholders throughout the Patient First Review.

Access issues were linked to the:

- Length of time that patients currently wait for certain services;
- Lack of availability and best use of health care providers;
- Lack of availability of services in rural, northern and remote communities,
- Number, location and role of facilities;
- Lack of availability and use of diagnostic equipment and treatment technology; and
- Range and quality of services provided.

Access delayed is access denied.

Sometimes, access issues had a fairly clear origin. For example, a number of working parents expressed frustration with the business hours observed by some health care facilities and programs. Limited weekday hours often force these parents to choose between earning income and keeping an appointment for their children.

On the whole, however, access issues are complex, and service gaps or delays in one area of health care create backlogs and bottlenecks in another. Therefore, a system-wide perspective is critical to address these issues in a meaningful and sustainable way.

Shorter waits for surgeries and diagnostic procedures

Our researchers consistently heard from patients who waited too long for surgical procedures. Long waits for surgery have dramatic implications for patients. Through dialogue and written submissions, I heard what waiting means for patients: their lives put on hold; loss of income, mobility, family interaction, social mobility, and confidence. They live with anxiety, fear and secondary complications.

Waiting changes people's lives, and the longer they wait, the greater the impact. Patients wait to see a family physician – many indicate that family physicians are not available to them. They wait to see specialists, then wait for diagnostic testing. Then they wait again to see their physician or specialist and then often wait for surgery. Access delayed is access denied.

> *"To me my condition is serious enough that I need to be on pain killers, but I'll just never make it to the top of the waiting list." (Patient)*

I heard from many patients that access to a lengthy surgical wait list or to a queue in an emergency room is not their notion of timely care.

Clinical pathways that set target timeframes and map the sequence of decisions and care for specific conditions are proving to be an effective mechanism for consistency and quality as well as reduced waits. I strongly support the recent efforts that the Ministry and the health regions have taken together to move forward in this regard, but more needs to be done, and it needs to be done expeditiously. The case study "Emma's Story" (available for reference at www.health.gov.sk.ca/patient-first-review) illustrates the current experience of waiting for and receiving hip replacement surgery, and what that care experience could be in a transformed health system.

Eliminating the backlog of patients waiting for surgery is a priority and a recommendation of this review. This includes, but is not limited to, a number of strategies:

- Providing more and better information to patients about their condition and treatment options, and ensuring patient participation, to the extent they desire it, in decisions about their care;
- Providing patients with the option of a "pooled referral", which should serve to reduce waiting times; patient choice is protected, as they would retain the ability to select their surgeon knowing what the waiting time would be;
- For patients with a desire to see a specific surgeon, providing them with information on that surgeon's wait times;
- Improving system efficiency by streamlining processes;
- Expanding surgical and diagnostic capacity with the assistance of independent partners who meet quality and safety standards; and
- Increased capacity for post-surgical supports such as home care and therapy services.

Addressing surgical and diagnostic wait lists is of critical importance. It demands full, mandatory participation and collaboration of health regions and health care providers. I urge the province to examine all options to address this top-of-mind patient concern. If the system's current configuration proves unable to address the backlog of patients awaiting surgery, the system must explore other alternatives.

The current situation provides an opportunity to innovate, and planning is underway for a freestanding ambulatory surgery/diagnostic centre in Regina, designed to perform surgical procedures more efficiently than in a hospital setting and enhance hospital operating room capacity for more complex surgeries, which are currently being cancelled at an unacceptable rate. If this initiative is planned and implemented appropriately and in a timely manner, it can serve as a model for all of Canada to transform the way tomorrow's care will be delivered.

Addressing surgical and diagnostic wait lists is of critical importance … I urge the province to examine all options to address this top-of-mind patient concern.

Wait lists *are* long

As of May 31, 2009:

- Over 27,000 people were on the surgical wait list; and
- 4,000 (16%) had waited longer than 12 months.

On March 31, 2009:

- Wait times for CT scans ranged from 20 days to 190 days depending on the region; and
- Waits for MRIs were 150 days in Regina and 390 days in Saskatoon.

Commissioner's Recommendations

7. That the health system take immediate action to improve Saskatchewan patients' surgical experiences, from initial diagnosis through to recovery, through an aggressive, multi-year, system-wide strategy that is reported to the public with clear targets and regular updates.

Patients awaiting placement in a hosptal bed are frequently held in the emergency department, resulting in backlogs and long waits for emergency services.

Making best use of facility capacity

While hospital beds are frequently under-used in rural areas, bed capacity is often maximized in larger centres (and often exceeded in Regina and Saskatoon's provincial hospitals). As a result, patients awaiting placement in a hospital bed are frequently held in the emergency department, resulting in backlogs and long waits for emergency services.

Changing population needs, along with ongoing workforce pressures, have created the need to examine hospital services with attention to:

- Reviewing the roles of hospitals or other facilities that are in close proximity or underutilized and redesigning their purpose based on the needs of the community;
- Determining which, if any, highly specialized services should be provided in one location (Regina or Saskatoon);
- Identifying those services that can be provided outside of expensive hospital settings in alternate sites (e.g. day surgery, diagnostic imaging) or, in some cases, a patient's home (e.g. dialysis);
- Improving sustainability of some hospital services which are regularly jeopardized by the closure of facilities when providers (often physicians) are not available; and
- Relieving pressures on the major hospitals in Regina, Prince Albert and Saskatoon, resulting from consistently high bed occupancy.

The cascading impact of backlogs and bottlenecks cannot be overstated and is well illustrated by former Saskatchewan Medical Association president Dr. Milo Fink, who said, "Resolving a series of bottlenecks is one of the most important challenges in improving access to care for the province's patients." During a recent tour of the emergency room at Regina's Pasqua Hospital, he noted that "12 of the approximately 45 patients in the ER had been waiting to be admitted, some for more than 48 hours. Meanwhile, fifty to seventy people were waiting for long-term care beds in Regina." (*Medical Post* June 2009) I personally visited the Pasqua Hospital, where I witnessed incredibly dedicated staff who were coping with 11 patients who had been housed in the corridor for more than 24 hours.

The emergency rooms in urban hospitals were identified as a serious pressure point in the system. In many respects, the emergency room has become the default option in health care and reflects the negative effects of access issues across the system.

> *"I don't understand why they can't tell you how long the wait is going to be when you're in the ER. It would make it more bearable."*
> *(Patient)*

Many patients resort to walk-in clinics, and many complained that the outcome was only to be referred back to their physician or to acute care services. Some jurisdictions have introduced 18-hour urgent care centres, located close to or adjacent to emergency rooms, that can respond to non-life-threatening conditions.

Through a blend of primary and emergency care, the purpose of these centres is to efficiently respond to health concerns that require attention but not the full resources of an emergency room, while freeing hospital emergency rooms' staff to attend to life-threatening conditions.

> *"There needs to be a back-up 24-hour on-site walk-in clinic to alleviate the clogs in actual ER."*
> *(Patient)*

> *"I believe our ER is used for a lot of things that aren't emergencies, and I think that is where we should have that help line."*
> *(Patient)*

Commissioner's Recommendation

8. **That the health system address inappropriate usage of emergency rooms by exploring the applicability of urban urgent care centres. The appropriate health regions should explore alternate financing partnerships in developing these projects, which incorporate state of the art design and leading technologies.**

Providers working to their full scope of practice

Given the current global demand for physicians and other health care professionals, it is unlikely that Saskatchewan will enjoy a surplus of providers in the foreseeable future. However, innovative and progressive approaches to the use of health care professionals' competencies and education can do a great deal to alleviate this pressure. Saskatchewan must enable all of its care providers to work to their full scope of training and practice. This would make a significant difference in care access for patients, particularly those who are without a family doctor.

Full scope of practice will free up physicians and other care providers for the activities only they can perform. Several medical leaders I spoke with estimated that up to 50 per cent of the work most Saskatchewan physicians do today could be done by other professionals. For patients' sake, professionals such as registered nurses, licensed practical nurses, nurse practitioners, pharmacists, paramedics, dietitians, chiropractors and physiotherapists should be entrusted with the roles that are appropriate to their training. If "it takes a village to raise a child", it also takes a health care "village" to deliver quality health care. All providers are dependent on other providers to ensure that patients experience a safe and high-quality journey.

For patients' sake, professionals such as registered nurses, licensed practical nurses, nurse practitioners, pharmacists, paramedics, dietitians, chiropractors and physiotherapists should be entrusted with the roles that are appropriate to their training.

Ongoing advancements in health care delivery and technology will create a need for new and evolving roles among care providers. Health care employers and training/educational institutions must work together to anticipate these needs in order to facilitate interprofessional practices.

A regulatory system that eliminates monopolies and restrictive scopes of practice and allows professionals to provide services to the full extent of their training should result in a more flexible, effective and efficient system that promotes quality care.

Patient First possible pathway: The Ministry of Health could engage with educational and professional representatives in a formal collaborative to develop a plan for optimizing the training and skills of health care professionals. This work could be an integral part of the Ministry's Health Human Resource Strategy and include professional reform as a means of expanding scope of practice and enhancing professional collaboration for the sake of patients.

> *"Nurses are so capable, and have so much knowledge, but they don't have the power, the doctors have all the power. They need to be better utilized."*
> *(Patient)*

> *"If every doctor's office had a nurse practitioner, it would cut down a huge amount of the physician's work load."*
> *(Health care provider)*

In response to concerns that patients cannot always find a specialist when needed, the Registrar of the College of Physicians and Surgeons has observed that some patients "fall between the cracks" of the health system as doctors become more selective in their scopes of practice. He suggested the medical profession needs to reflect on this scope-of-practice trend and its impact on patients.

I also heard that while registered nurses provide certain types of care in some settings, that same care is provided by licensed practical nurses in other settings. Surprisingly, clinical roles and responsibilities are sometimes determined on a unit-by-unit basis. A regulatory system that eliminates monopolies and restrictive scopes of practice and allows professionals to provide services to the full extent of their training should result in a more flexible, effective and efficient system that promotes quality care.

To date, professionals have expressed openness to expanded scopes of practice in theory, but in reality have been hesitant to relinquish responsibilities to others. Reforming and modernizing the regulation of health professions could provide the impetus for collaborative practice – an opportunity that Saskatchewan cannot afford to miss, for the sake of patients.

If necessary, new health care professions could be added to address capacity gaps. However, new roles and additional credentials for existing professions must be thoughtfully considered to avoid unintended consequences for the supply and affordability of health professionals.

5. Communicative, Informative Care

What it looks like: ***Patients are always well informed about their health and the factors affecting it, treatment options, and the "5 W's" of their next care steps (Who? What? When? Where? Why?). Providers take the time to explain, to clarify, and perhaps most importantly, to listen to patients and their families.***

Patients and families have always had the need for, and the right to expect, clear and helpful information about their health-related issues, their options, next steps, and what they can expect along the way. As developing technology continues to make information more readily available and easily shared, there are fewer excuses for failing to provide patients and families with the information that can make the difference between a positive health care interaction and a negative experience.

Patients and families have always had the need for, and the right to expect, clear and helpful information about their health related issues, their options, next steps, and what they can expect along the way.

Committee's Recommendation

9. That the Ministry of Health, in collaboration with health regions, the Cancer Agency, provider organizations and patient and family advisors, develop and implement a Charter of Patient Rights and Responsibilities.

Understanding of rights and responsibilities

Patients want to know what they can expect from the health system and, in turn, what those in the system should reasonably expect from them. An overarching statement of patient rights would formalize the province's commitment to patient-and family-centred care, while reinforcing an individual's responsibility for their own health and responsible and appropriate use of the health system. This could be achieved through a Charter of Patient Rights and Responsibilities, which could include a range of provisions such as: principles (fairness, accountability, and transparency), patient rights (dignity, respect, safety, informed decision making, disclosure, and consent), mechanisms for recourse or appeal, as well as a statement of patient responsibilities such as asking questions, sharing information, or maintaining a healthy lifestyle.

Patients must be free to communicate their questions, concern and fears, and to receive the information they need to fully participate in their course of care and treatment.

Better communication, more information

Positive relationships and effective communication between care providers are essential for quality patient care and professional satisfaction. Communication between providers is a cornerstone of an effective and efficient health care enterprise.

Communication between the patient, the patient's family and care providers was a recurring theme in patient focus groups, interviews and small-group discussions. Many patients recounted experiences of being confused or uncertain about diagnosis, treatment options, protocols, and next steps. The behaviour and attitudes of physicians, nurses and others in the health system were often described as exemplary; however, they were also described too frequently as dismissive, disrespectful and uncaring.

> *"He made me feel like I wasn't a person, just a number to push out the door as quickly as he could."*
> *(Patient)*

> *"I feel like even when I do ask a question, they are brushing me off. They look at me like 'why are you asking me these questions?'"*
> *(Patient)*

Patients must be free to communicate their questions, concerns and fears and to receive the information they need to fully participate in their course of care and treatment. They must understand their condition, their treatment options and their responsibilities. Providers, in turn, must recognize that patients have unique insights about the status of their health and a desire to share both responsibility and decision-making about their care and treatment options.

> *"Physicians are experts in a particular field of medicine, but patients are experts on how they feel."*
> *(Patient)*

Patient- and family-centred care provides patients with information throughout their care journey. They should know the expected next steps, receive regular updates on the timing and progress of their care, be able to reach a provider when needed and be informed about what to expect when discharged from care.

Many of the ideas presented by patients, providers and stakeholders are consistent with practices in health care systems that have adopted patient- and family-centred care. Patients are encouraged to bring family members or other supports to their appointments to ensure important information is heard, remembered and/or recorded. Patients and their family members are encouraged to ask questions, provide information and explore options. Providers ensure that patients are fully informed and understand next steps, options and responsibilities. This is particularly important at the time of discharge from a facility and when moving from one part of the system to another. A strong provider-patient relationship and a health system that encourages communication and inquiry will support patient safety, avoid unnecessary recurrence, relieve patient anxiety and invite shared or informed decision-making.

Good decisions are made when the patient is informed and understands the implications of a choice, there is evidence supporting the choice, and the patient's values and preferences have been respected. In other words, the partnership includes an expert on the facts, the health care provider, and an expert on what matters most, the patient. The combined expertise is applied to arrive at the "right" decision for that individual at that time.

Patient First possible pathway: The health system, in partnership with patient and family advisors, could develop and demonstrate a decision-making model that empowers patients to take an active role in decisions related to their care and treatment.

Two-way communication: the opportunity for feedback and recourse

Patients want their voices to be heard and acted upon when their health care experiences prompt them to speak out. When they encounter serious concerns, including quality-of-care issues and decisions respecting health coverage, they seek formal appeal mechanisms that allow for an objective review of those concerns. A patient- and family-centred health system requires a culture that invites and acts on positive and negative commentary and implements accessible and public recourse and appeal mechanisms. Discussions with the Ombudsman of Saskatchewan should explore ways to strengthen the opportunities for public feedback and recourse concerning health care.

One of the most powerful ways to build a sustainable, patient- and family-centred health system is to help Saskatchewan people avoid becoming patients in the first place.

There are tremendous opportunities for this kind of two-way communication whenever a health care program is undergoing an evaluation or changes of any kind, or when a new program is being considered. This is when program planners, designers and providers can actively seek patient and family input, thereby embedding the Patient First philosophy into the very fabric of the service.

6. Comprehensive Care

What it looks like: ***Health care providers are attuned to all, not just some, of a patient's needs, and are equipped and empowered to deliver holistic care that respects the complexity and interrelation of physical, psychological, spiritual, and socioeconomic factors. Patients and families are given the time to express their needs.***

Keeping people healthy

By its very nature, a Patient First review must focus its findings and recommendations on patients – those people who, for any number of reasons, find themselves in need of health care services. From its very conception, this review was intended to scrutinize Saskatchewan's network of health care programs and services from the perspective of the people who use them. The recommendations contained in this report, therefore, contain ideas for improving the patient journey – making health services more accessible, better coordinated, and more patient-centred.

It is critical to note, however, that most Saskatchewan people have no great desire to become patients in the first place. At best, what we call the patient journey is usually an inconvenience to the person making the journey – they are diverted from family or work or other important areas of their lives in order to resolve a health-related problem. At worst, the journey can be catastrophic – a serious illness or injury that changes the entire trajectory of a person's life and the lives of those who care about them. This is why the patients we spoke to ask to be treated with compassion, dignity, respect and sensitivity. Very few of us want to be patients, and the journey can be profoundly difficult and upsetting.

One of the most powerful ways to build a sustainable, patient- and family-centred health system is to help Saskatchewan people avoid becoming patients in the first place. This is one element of truly comprehensive health care — educating, enabling and empowering individuals and families to protect and promote their own good health.

There are many factors that play an important role in determining the levels of health and well being we enjoy throughout our lives. These include our income and social status, our levels of employment, education and literacy, our social and physical environments, formative childhood development and experiences, social support networks, our personal health practices and coping skills, quality and availability of health services, biology and genetics, gender, and culture.

Enlightened public policy can do a great deal to help people stay healthy. We also need to promote the realization that to a great extent we are in charge of our personal health.

We now know that many illnesses and injuries are entirely preventable. If we learn how to maintain our own health through proper nutrition and exercise, or care for our own safety by adopting safe practices at work, home and play, we will likely cut down significantly on the number of 'patient journeys' we need to make in our lifetimes. Even as we begin to experience the inevitable effects of aging, we are more likely to remain healthy, mobile and independent for a longer period of time.

Of course, some illness and injury is unavoidable or due to factors beyond our control, such as genetic inheritances, reckless activity by others, or simple bad luck. While some of us have ongoing and intensive health care needs that require more frequent interactions with the system, the majority of Saskatchewan residents will receive at least one type of health care service over the course of a year.

But imagine how many resources in the system are freed up by just one socioeconomically disadvantaged youth who, thanks to early intervention and education, avoids a lifetime of addiction. Imagine the benefits to the individual and society when a person with Type II diabetes is helped to manage their condition and thereby becomes dependent on intensive medical intervention much later in life. Imagine the difference made by one safe driver, or by one person who quits smoking — or better yet, doesn't start smoking in the first place. Prevention of illness and injury means fewer patients, which means more readily available resources for those who need the health system[11].

In personal-finance terms, this is known as paying yourself first – making a long-term investment now that pays huge dividends in the future. Several of this report's recommendations require up-front, one-time investment of fiscal and human resources if they are to answer Saskatchewan patients' calls for a better health system. However, the 'problem' of sustainable, quality health care will never be addressed by short-term spending.

That is why I urge the Government of Saskatchewan to pay itself first – in fact, to pay the citizens of Saskatchewan first – by emphasizing health promotion and the prevention of illness and injury[12].

Commissioner's Recommendation

10. That the Saskatchewan government and health system pursue an aggressive and targeted emphasis on the promotion of good health and the prevention of illness and injury in Saskatchewan. Not only will this pay dividends in a healthier and more productive populace, it will help to ensure that Saskatchewan's health system is ready and able to help all of us when we need it most.

More time with the patient

Patients and providers alike expressed the need for more time for direct interaction. Saskatchewan, like other jurisdictions, has addressed workforce capacity through recruitment and retention strategies (i.e. international recruitment, expanded training seats, bursaries, relocation bonuses, and higher wages). These strategies are important, but are not sufficient to respond to service expectations and increased demand. Saskatchewan's number of physicians per 100,000 population is lower than most other provinces.

> *"But the burden to change the system falls on the leaders, the stewards, and the people who create the organizations where the workforce works. Doctors want to do their work in a patient-centred way; they really do. We have to fix the health system so that it gives doctors the time to do the job they want to do."*
>
> *(Pauline Chen M.D.)*[11]

The province has been applying lessons learned and best practices from high-performing health systems in other jurisdictions. Releasing Time to Care, an initiative led by the Health Quality Council, was first implemented in the National Health Service in England. Its purpose is to create more time at the bedside for hands-on care. It focuses on freeing up caregivers' time for more direct patient care. Nurses and other caregivers often spend time away from the patient hunting for supplies, searching for information about patients and their plan of care, duplicating charting, and dealing with constant interruptions. Releasing Time to Care helps care teams identify where they are spending time on activities that do not add value for patients and provides guidance on implementing changes to improve care.

Improvements to nursing unit processes and work environments help providers spend more time on patient care.

Releasing Time to Care is currently being piloted in the Five Hills and Regina Qu'Appelle Health Regions. Plans are now underway to roll the initiative out to all health regions. Early results are demonstrating that improvements to nursing unit processes and work environments help providers spend more time on patient care. Standardized, efficient processes supported by technology will also enable more patient-provider time.

The province is well equipped to take a creative and powerful approach to human resource planning that will, in concert with other initiatives, address many of the system's capacity issues. A physician recruitment and retention strategy, announced in May 2009, is in the early stages of implementation. Legislative Secretary Laura Ross has recently led a comprehensive examination of nursing recruitment and retention issues. The administrative research undertaken as part of the Patient First Review provided additional insights into workforce capacity. This information can and should be used to inform the development of a new and visionary health human resource strategy that moves beyond the traditional approach.

Patient First possible pathway: The Ministry of Health's 10-Year Health Human Resources Plan, currently under development, should not be based upon the 'status quo' for health service delivery in Saskatchewan, but upon a provincial model for health services that is guided by the Patient First Review's findings and recommendations, anticipated population health needs, and evidence-based best practices. Only in this way, and in collaboration with health regions, the Cancer Agency, and health professions' groups and unions, will this plan help to build a patient- and family-centred health workforce designed to meet the unique needs of Saskatchewan's people and communities.

Primary health services as a priority

Primary health services represent the first level of contact between individuals or families and the health system. It is often referred to as "every-day" health care and is closely connected to public health, health promotion, and community development activities.

Effective primary health services represent some of the most promising routes to improving the comprehensiveness of Saskatchewan health care, and yet there has been minimal progress in the formation of primary care teams in Saskatchewan. As of March 31, 2009, primary health services teams were serving only 31 per cent of Saskatchewan's population. A fundamental re-design of primary services delivery is urgently required in this province to serve patients better.

Some primary health service providers work in interdisciplinary teams to provide care. Although collaborative care has been in use for decades in other high-performing health systems such as the Mayo Clinic and Kaiser Permanente, Saskatchewan has yet to realize the full benefits of team-based care or technological supports such as telehealth, remote monitoring, the internet, and e-mail communication.

Primary health services represent some of the most promising routes to improving the comprehensiveness of Saskatchewan health care, and yet ... [they are] serving only 31 per cent of Saskatchewan's population.

A number of potential barriers may be impeding the full expression of primary health services in the province. These include lack of information technology support, disincentives created by compensation systems, and lack of physician leadership and participation on primary service teams.

It is my belief that the Ministry of Health and pertinent health care provider associations need to collaborate on a fundamental re-thinking of what constitutes a 'primary health services' facility, site or team in Saskatchewan. Both parties need to put the patient first in these discussions and reach an agreement that will result in a proliferation of primary health service sites throughout the province.

The Mobile Primary Health Centre in Saskatoon, locally known as the Health Bus, is an example of an innovative, award-winning approach that responds to the health needs of a previously under-served population[14]. The bus, staffed with a nurse practitioner and emergency medical technician, offers health services in locations and at times that meet the needs of the community.

In Nova Scotia, paramedics are used to deliver mobile health care services in rural communities, providing chronic care in patients' homes and preventive care in community clinics. These paramedics and their ambulances remain available for emergency calls, but lend their training and expertise to the health system when not out on a call.

By helping patients understand their condition and know where to turn for advice and support, primary health services improve their quality of life and reduce their reliance on more intrusive and costly acute care.

> *"There is a diabetes collaborative in place in my community. Access to lab testing is quick. We have a nurse educator to assist in care if needed."*
> *(Patient)*

Primary health services can have a tremendous impact on the management of chronic disease. One in every three Canadians lives with a chronic disease such as diabetes, cardiovascular disease, arthritis, cancer, asthma, chronic respiratory disease, or a mental health disorder, and their incidence is on the rise. Traditional care approaches, with the physician as sole provider, do not always serve this population well: appointments are often rushed and the physician may not effectively connect the patient with community supports.

By helping patients understand their condition and know where to turn for advice and support, primary health services improve their quality of life and reduce their reliance on more intrusive and costly acute care. The current economic impact of chronic disease in Saskatchewan is estimated at $1.9 billion per year in direct health care costs and $2.5 billion per year in indirect costs associated with lost productivity and income. The case study "Walter's Story" (available for reference at www.health.gov.sk.ca/patient-first-review) illustrates the complexity of chronic care in the absence of a primary health services team that employs leading practices.

The Saskatchewan Chronic Disease Management Collaborative initiated by the Health Quality Council in 2005 is one approach used to improve quality of care for people with chronic conditions.

About 18,000 people with coronary artery disease or diabetes were involved in the collaborative along with 25 per cent of all family physicians and hundreds of other health care workers. By improving quality of care and access to health providers, improvements in key clinical measures for these conditions were achieved The next collaborative, which will focus on chronic obstructive pulmonary disease (COPD) and depression, is expected to be launched by the Health Quality Council this fall.

11. **That the health system develop and implement a province-wide chronic disease management strategy that ensures patients receive evidence-based, standardized care, wherever they live, and connects patients with multidisciplinary health care teams.**

Primary services and substance abuse

Saskatchewan has participated in the development of The National Treatment Strategy, a pan-Canadian working group charged with developing recommendations for people with substance abuse problems. Its report recommends a flexible, tiered model of services and supports that effectively matches the intensity of the treatment to the intensity of the addiction problem. The report highlights the key role played by primary health services in responding to substance abuse problems when they are presented. An increased focus on primary health services will allow treatment providers such as longer-term residential addiction programs to focus their services more effectively.

Health care is about much more than science and medicine. It's also about relationships.

Addiction issues are among the most challenging for a health system that wants to deliver comprehensive care. Individuals with complex mental health issues, addictions issues, justice issues and/or disabilities such as acquired brain injuries require enhanced case management that will address a continuum of needs. It is important that health and allied professionals are given the training and supports to enhance their ability to help patients and families with alcohol and drug issues.

7. Respectful Care

What it looks like: ***Patients are treated with empathy and understanding for their fears and hopes. The relationship between patient, family and provider is a balanced, mutually respectful partnership, not an imbalanced power dynamic that favours the provider.***

"We don't want them to be dismissive or belittle our concerns. After all, we are not only a lump in the breast, or a damaged heart – we are people who seek your help."
(Patient)

"When you go to the ER, it's almost like you are intruding on the nurse's time. They have their tasks they need to do, and they are always so busy doing their tasks that it's almost like a 'don't bug me, you are invading my space' attitude, which is very frustrating."
(Patient)

The Patient First Review has reminded us that health care is about much more than science and medicine. It's also about relationships.

We repeatedly heard about the importance of the provider-patient relationship and the qualities that make a good relationship – respect, time, listening, clear communication, openness, empathy and understanding. The importance of relationship does not discount the need to change how health care is designed, organized and delivered, but it does redirect our attention to the quality of interaction – the attitudes and behaviours – between health care providers and patients. The importance of this relationship to patients cannot be overstated. Their health and their lives are at issue.

"We want safe, quality care, delivered within a reasonable timeframe by health care providers who are kind, respectful, empathetic and caring."
(Patient)

Patient-centredness is not about refocusing on patients to the detriment of providers. A patient- and family-centred system provides a safe and high-quality care experience for patients and a rewarding work environment for providers. Our research showed that patients and frontline care providers shared similar views on the issues and solutions in health care.

Meaningful, positive interactions between patients, families, and providers

During our consultations with patients, the quality of interaction between patients and health care providers received mixed reviews. Patients recounted troubling examples of inappropriate conduct which were subsequently affirmed by providers and managers. A variety of causes were identified, ranging from the complexity and time-demand of addressing staff performance to the lack of system support for staff. Rude, demeaning or rough treatment of patients cannot be tolerated, especially when it involves seniors. Leaders, human resource managers, union representatives and regulatory bodies must accept their responsibility and send a clear message that such behaviour is unacceptable.

Rude, demeaning or rough treatment of patients cannot be tolerated, especially when it involves seniors. Leaders, human resource managers, union representatives and regulatory bodies must accept their responsibility and send a clear message that such behaviour is unacceptable.

Across the country, nursing management has shifted from a clinical to an administrative focus, with significantly expanded responsibilities. Some nurse managers are responsible for 50 to 200 staff members who work at more than one site and include both clinical and non-clinical staff representing diverse training, job functions and responsibilities. Both literature and the individuals consulted for this review report undesired consequences in patient care, management of staff and work unit culture, and job satisfaction. Nurse managers' roles have become increasingly complex. On top of this, nurse managers often carry the additional work burden associated with introducing new programs or initiatives in their nursing units or facilities.

Nurse managers' time must be freed up for clinical responsibilities, including oversight and accountability for patient care, and mentoring, coaching and developing staff[15]. Their job descriptions should be clear and unequivocal in emphasizing these clinical responsibilities. The Ministry of Health, meanwhile, should consider what could be done to support health regions in training these and other frontline 'care culture leaders' and implementing patient- and family-centred care practices.

> *"...it all depends on the relationship you have with your physician whether they advocate for you....."*
> *(Patient)*

> *"I don't think he hears me when I talk."*
> *(Patient)*

Many patients described their overall health care experience as positive or negative based on their experience with their physician.

Patients want physicians who can understand their needs as a whole person. Physicians have long described their role as being, in part, an advocate for their patients. Yet hurried visits, poor scheduling, minimal dialogue, poor engagement, and a myriad of independently developed protocols do little to put the patient first. The same can be said of systemic disincentives, fiscal and otherwise, that reward volumes more than quality of care.

The question of "who owns the patient" was frequently raised in relation to managing the complexity of the health system or providing an ongoing resource for advice and information. In a modern health system, the physician's role needs to shift to include helping patients to self-manage and participate in their care. It is time that providers and the system recognized that the bulk of a patient's care needs will, over time, be met by the patient himself/herself or by his/her family/friends. The health system must support physicians in making this shift and patients in understanding the importance of their own role.

In fact, providers need to trust and encourage patients who want to be actively engaged in the management of their own health. Health care should be a partnership between patients, their families and providers, not an imbalanced power relationship.

Patient First possible pathway: Health regions could provide nurse managers with the tools they need to spend more time supporting their staff's engagement with patients.

Cultural competence and safety for First Nations and Métis people

First Nations and Métis participants in the Patient First Review identified examples of understanding and accommodation of their cultural needs and differences through programs and services provided by the All Nations Healing Hospital in Fort Qu'Appelle, Saskatoon's Mobile Health Bus, and the spiritual room at the Pasqua Hospital in Regina. However, many troubling experiences were also brought forward.

While First Nations people on reserve have access to prescribed federal funding for medical transportation, some Métis and First Nations people in remote northern locations expressed feelings of displacement and isolation when they traveled long distances alone for care, particularly when English was not their first language. Such feelings were not confined to residents in the north. First Nations and Métis residents across the province indicated they were less likely to ask questions of their health providers when they didn't understand what was said either due to language, providers' accents or medical terminology. And many experiences reflected a sense of being treated differently because of their cultural background.

> *"Now relating to the Cardiac Rehab program, I notice that it appears to be for white people only. No Aboriginal people there except myself. When I asked the staff about this, they said yes, the Aboriginal people don't seem to come. And Cardiac Rehab is doing what to address this? I also noted that in the Diabetes Education program that Aboriginal people do not come, either. This inequity needs to be addressed, especially with the numbers of Aboriginal people with diabetes and heart disease."*
> *(Patient)*

> *"I haven't been able to talk to anyone about the prejudice – I think that's the way it is. A white woman in the ER had stubbed her toe and she was taken in before me, even though I had been there for 4 hours and was really sick. Nurses have made inappropriate comments that were rude and not called for. I just let it go, because that is just the way that some people are and it's not going to change."*
> *(Patient)*

In order for the Saskatchewan health system to effectively administer patient- and family-centred care to First Nations and Métis people, it must incorporate both cultural safety and cultural competence concepts. Typically, health regions engage their employees in cultural awareness and sensitivity training activities, which assists them in recognizing their personal attitudes and biases toward First Nations and Métis people and educates them about these cultural groups' customs, beliefs and behaviours. However, the next step for these and other organizations is to adopt an agenda of cultural **safety** along with cultural **competence**. Like patient safety, cultural safety exists when the patient feels safe and involved in their care, and the provider is aware of her or his own attitude while delivering care.

Cultural competence builds on these personal interactions between patient and provider, and addresses First Nations and Métis care at the system level by incorporating culture into health care delivery practices. Every working part of the system must align its behaviours, attitudes and policies to ensure its First Nations and Métis patients are effectively and respectfully provided the care they need. Each staff person, professional group, health region or health care organization and the system itself must "address collective issues of equity in health care access and health outcomes." (Nguyen, 2008)

Every working part of the system must align its behaviours, attitudes and policies to ensure its First Nations and Métis patients are effectively and respectfully provided the care they need.

Saskatchewan has begun this journey through its participation in the Aboriginal Health Transition Fund, the Memorandum of Understanding on First Nations Health and Well-Being and its renewed partnership with the Métis Nation - Saskatchewan. Through these processes, gaps in services for First Nations and Métis people are being identified and discussions are being held as to who is in the best position to deliver needed services and who is responsible for the funding of these programs and services. I have confidence that through these initiatives and others, through a transformation to patient- and family-centred care that incorporates cultural safety and competence, and through the concerted effort of all, that the health and well-being of First Nations and Métis people will improve.

12. **That the health system, in collaboration with First Nations and Métis Elders, and patient and family advisors, work to develop a culturally safe and competent health system that better serves First Nations and Métis citizens.**

8. Functional e-Health Care

What it looks like: ***Patients only need to provide information once, after which it becomes accessible to those who need it to deliver care. Patients have ease of access to their health records and the opportunity to add information.***

Patients and providers alike spontaneously identified the system's inability to collect and share vital, personal health information electronically as a key barrier to integrating health care. Patients complained about having to repeat their histories to several different providers at several different sites, or being asked to elaborate on or explain the decisions or recommendations of another provider. Clinicians too often depend on a patient to inform them about previous reactions to medications or other important details, as these often slip through the cracks when information is not shared between sites in a consistent, reliable manner.

An electronic health record was most frequently identified as a solution to these issues. The electronic health record is a series of information systems and technological infrastructure that, when integrated, will enable health care professionals to share patient information efficiently and securely.

> *Put e-records in every doctor's office, new [Canadian Medical Association] president says: [Dr.] Anne Doig believes goal to have electronic records in place by end of 2011 part of shift to patient-centred care*
> *(GlobeandMail.com headline, August 19, 2009)*

In addition to the need for electronic health care records, patients identified challenges in navigating what can be an overwhelmingly complex system.

One patient – one record

Numerous patients have multiple, redundant patient records scattered among several health care facilities. Saskatchewan patients repeatedly provided examples of misplaced, unavailable, or scattered health information and consequent errors, adverse events and duplication of costly and/or painful tests and procedures. Accessible patient information is vital to improving service integration and coordinating patient care.

Saskatchewan remains largely paper-based, with ... manual records which cannot be readily transferred from one part of the health system to another.

> *"An electronic health record would be worth its weight in gold. People die waiting for the mail or returned phone calls."*
> *(Patient)*

> *"Files should be transferred so that a history can be maintained through to new doctors. At least that way the new doctor will know what was going on at the time, and can move forward from there. Why wouldn't your new doctor want to know what you have been through so far, because how are you supposed to remember everything yourself? I just want to get everyone on the same page and that shouldn't be a crime, especially when you put your trust in your doctors and the health care system."*
> *(Patient)*

The future of health care in the province has everything to do with reducing long wait times, streamlining the patient journey, unclogging emergency rooms, reshaping the primary-services model, moving care closer to home, adopting leading clinical practices, managing chronic diseases, designing the system around patient needs, and promoting healthy lifestyles. This is a tall order for Saskatchewan's 40,000 care providers, even those who expressed openness to positive change. Information technology is a prerequisite to improving patient care and safety, reducing costly duplication and delays, and supporting increased accountability.

In the health sector, investment in information technology (IT) is substantially below that of other industries that have seen the benefits of IT in enhanced service delivery. Health is one of the least technologically developed sectors. Saskatchewan remains largely paper-based, with most practitioners writing diagnostic and therapy orders and maintaining manual records which cannot be readily transferred from one part of the health system to another. Yet the highly complex nature of health care demands greater access to information through technology.

Health care involves many points of contact between patients and care providers. General practitioners, specialists, pharmacists, technicians and nurses, in both urban and rural locations, may all be involved in a patient's care and work out of both hospital and community-based settings. Historically, there has been no means of electronically recording and transmitting information between care providers. This forces patients to provide their health history and related information multiple times and obligates providers to duplicate costly tests.

> *"Our files are all on paper only, so when people are asked to go to the city to be treated, their files don't follow them there."*
> *(Health care provider)*

> *"How can a doctor make a diagnosis if they don't have all the information?"*
> *(Patient)*

The Ministry of Health has made progress. The three major components of the provincial electronic health record currently in development are:

1. The electronic health record project – which provides provincial data repositories for clinical use (i.e. radiology and laboratory tests);
2. Electronic medical records – computer systems to support physicians in creating electronic charts and sharing patient information across the province; and
3. Integrated clinical systems in health regions – enhancing and upgrading systems such as the Mental Health Information System, and Procura, the home care information system used by staff in health regions and the Ministry.

Canada Health Infoway was established in 2000 as an independent not-for-profit corporation with the mandate to build the foundational elements of an electronic health record for use across Canadian jurisdictions. Through this organization, the province can leverage federal funding with the appropriate business case.

Now is the time to accelerate electronic health record development. Patient, provider, and health stakeholder support is strong, federal funding is available, and many components of the provincial electronic health record are works in progress.

Patients will soon demand easy and immediate access to their own health care records. Patients expect to be better informed about their health conditions and treatments.

Now is the time to accelerate electronic health record development. Patient, provider, and health stakeholder support is strong, federal funding is available, and many components of the provincial electronic health record are works in progress. However, without significant and sustained investment, those initiatives will not translate soon enough into tangible benefits such as improved access, safety, quality, and communication and information-sharing for the patient. The province should seize this opportunity and develop a provincial game plan that will lead to successful implementation.

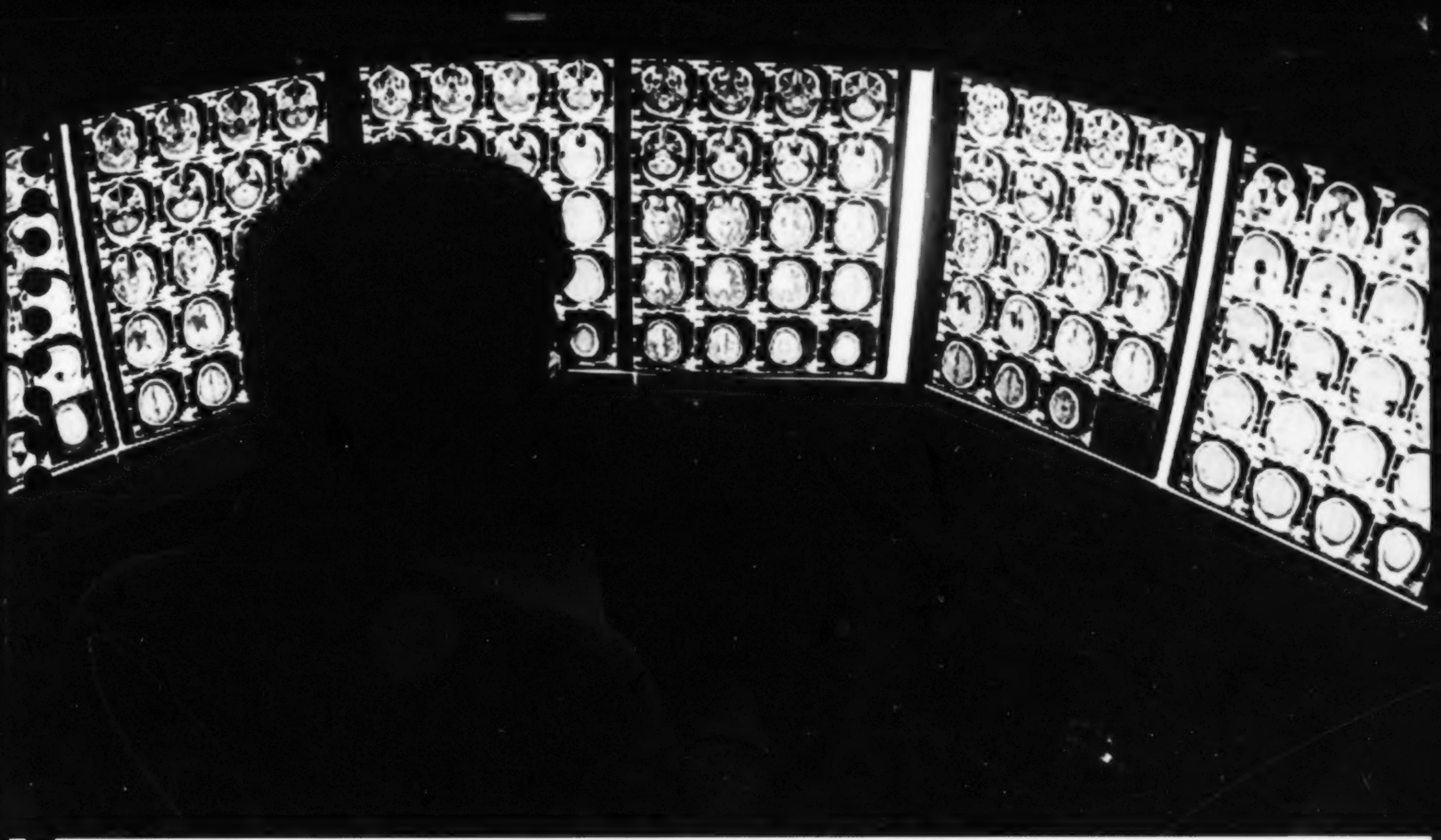
As is typical of a provider-centred health system, patients' health information has been considered the providers' property. Patients wanting to access their medical records often face numerous hurdles in doing so. I strongly suggest that the Information and Privacy Commissioner be involved in formulating policy regarding appropriate access to health records. When almost every other industry in the developed world is utilizing technology to make information more readily accessible to its customers, we can expect that patients will soon demand easy and immediate access to their own health care records. Patients expect to be better informed about their health conditions and treatments.

> *"There is a real lack of transfer of patient records. My mom has moved out of Prince Albert, but she has years and years of medical issues and I would really like the doctor where she is now to have access to all of those interventions."*
> *(Patient's family member)*

Commissioner's Recommendation

13. That the Ministry of Health, in consultation with the health regions, the Cancer Agency, and clinical leaders invest in and accelerate development of provincial information technology (IT) capabilities within a provincial framework. This will involve:

- **a) Developing an e-Health implementation plan by early 2010;**
- **b) Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and**
- **c) Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.**



II. Improving System Performance and Leadership

Health care in Saskatchewan is provided through a network of professionals and agencies that include the Ministry of Health, 13 health regions including the Athabasca Health Authority, the Cancer Agency, 40 affiliated health care organizations and approximately 40,000 health care providers, some of whom operate in independent practice. The interaction between these agencies and professionals has a significant impact on the quality of patient care and overall patient experience.

The concerns that were expressed about the lack of coordination and integration in the health system, as well as the difficulties that many patients had in navigating the system, tell me that the health system is not functioning as a "system." This quasi-network of somewhat independent agencies and professionals must begin to think and act as one system for the benefit of the patients. The role and relationship of the Ministry within the health sector must also be made more clear.

The health system is not functioning as a "system." This quasi-network of somewhat independent agencies and professionals must begin to think and act as one system for the benefit of the patients.

Effective governance, high-performing management

> *The regional structure is intended to ensure responsiveness to local needs. Consequently, this model also leads to variations in leadership style, management performance and capacity for service delivery.*

In 1993, regionalization was a defining milestone in Saskatchewan health care. In what has been described as "a tidal wave of change", health regions assumed responsibility for the planning, budgeting, organization, delivery and evaluation of health services. The community-based nature of the regional structure is intended to ensure responsiveness to local needs. Consequently, this model also leads to variations in leadership style, management performance and capacity for service delivery. The health regions differ significantly in size, scope and the nature of their activity. The province's two largest regions include half of the province's population, more than half of the health services activity and almost 60 per cent of the health budget that is allocated annually specifically for health region base operating costs. In addition, health regions receive additional funding for capital and other project-specific initiatives. Acute care activity is a dominant health service in the urban regions, while long-term care is a dominant service in most rural areas.

The administrative component of the Patient First Review was designed to determine whether the health system is "over-resourced, under-resourced or over-managed." Enablers of, and barriers to, system effectiveness were to be identified and improvements suggested. Corporate functions subject to review included general administration, finance, human resources, information technology, and nurse management. All health regions, the Cancer Agency, and SAHO came within the review's scope. Affiliates were also consulted about their working relationship with health regions.

Findings as detailed in Deloitte's report (available for review on www.health.gov.sk.ca/patient-first-review) show that while the province's relative level of resourcing for combined administrative areas (which includes general administration, finance, human resources, and information technology) is lower among Canadian jurisdictions, there are a number of considerations that provide important insights:

- Low relative resourcing is driven by general administration and information technology (IT), and does not necessarily represent efficiency, effectiveness or value.
- While general administration spending is lower compared to Canadian jurisdictions, Saskatchewan has greater relative spending on board and executive costs, which leaves fewer resources for key general-administration support functions such as strategic planning/decision support, quality/risk management, and patient safety.
- Lower IT resourcing translates to insufficient resourcing across health regions, where IT is not able to meet the business requirements in many organizations, and will be challenged to support the provincial e-Health strategy going forward.
- Finance and human resources have higher relative resourcing compared to Canadian jurisdictions.
- These functions are largely transactional in nature, particularly in the non-urban regions, and the needs of internal customers (i.e. managers/employees) are reportedly not being met.

- The current corporate management model is not sustainable from a workforce perspective. In particular, finance, human resources, and IT functions are experiencing and anticipating recruitment and retention challenges of qualified leadership and frontline staff.
- Economies of scale are difficult to achieve, given the duplication of transactional functions across 14 service provider organizations.
- Varying levels of consistent strategic leadership are evident across provider organizations, including affiliate organizations.

Economies of scale are difficult to achieve, given the duplication of transactional functions across 14 service provider organizations.

Focus group discussions with affiliate organizations (e.g. faith-based facilities and services) indicated their desire to receive more attention from regional leadership. Some affiliates feel orphaned from the regions' strategic planning processes, despite their willingness to become involved.

We heard numerous concerns from patients, frontline staff, and the public, that health regions were becoming a "growth industry for management." This perception seems often to be aggravated by a lack of understanding among frontline staff and community residents as to the purpose and value of newly created management positions. In an environment where health care resources are often stretched to the limit, patients and frontline staff need to see a direct link between a manager's role and patient care. It is incumbent on each region to ensure that link exists and to communicate it to the public and to regional staff.

The review also identified differences in the nature of the administrative functions performed in the health regions, which tend to be more heavily weighted to the transactional (as opposed to strategic) in the non-urban health regions. As a result, these health regions have less capacity to support functions requiring higher-level planning and analysis. Questions were raised about the efficiency and cost effectiveness of functions that are duplicated across regions and about the capacity of small and medium-sized regions to respond to the demands of a changing and complex environment.

An additional, pragmatic consideration is the capacity of the managerial workforce. Not unlike the clinical areas of the health enterprise, administration is also experiencing workforce pressures. There have been instances where health regions have been unable to consistently carry out essential corporate functions due to workforce shortages.

In an environment where health care resources are often stretched to the limit, patients and frontline staff need to see a direct link between a manager's role and patient care.

Leading and sustaining change must be a priority for health regions. Given the scope of transformation recommended in this report, making it happen is no small feat. However, for the sake of tomorrow's patients, inaction is not a viable option. At the same time, each region must ensure it has adequate and meaningful leadership involvement from its medical staff.

It is time that business be done differently and better for the sake of patients. Health regions must ensure best value is harvested province-wide in the purchase of goods and services required to deliver quality health care. In other provinces, numerous non-clinical and clinically-related corporate functions have adopted alternate service delivery models. Health regions would be well-advised to explore some of these successful models for possible applicability in Saskatchewan.

Province-wide purchasing of goods and services will substantially increase the province's buying power and save resources for all health regions so they may be allocated to direct patient care.

Inaction by health regions, affiliates, SAHO, and the Cancer Agency, along with physician and provider preferences among health regions, have cost the province millions of dollars in unrealized savings over the years due to the absence of province-wide purchases of supplies, equipment, and services. Recent announcements in Alberta and B.C. attest to a compelling need for the Saskatchewan health care enterprise to finally come together for the benefit of taxpayers. Province-wide purchasing of goods and services will substantially increase the province's buying power and save resources for all health regions so they may be allocated to direct patient care.

A new, provincial, shared-services organization should be established to undertake supply-chain management and standardization at a provincial level. This would signal a new way of doing business on behalf of Saskatchewan people. All health regions, affiliates, and the Cancer Agency must be full participants if maximum value is to be achieved.

An expert board of directors can work with the Ministry of Health, health regions and respective affiliates, and the Cancer Agency in defining the new organization's mandate. Strong corporate leadership will be needed to break through traditional ways of doing business and enshrine a province-wide perspective. Only then will value-for-money be realized for Saskatchewan citizens.

Providers have a leadership role to play in evaluating and standardizing health system equipment and supplies. The key to success is a strong resolve on the part of health regions, respective affiliates and the Cancer Agency to share as many services as possible. Adopting new and enabling technologies will be essential to this new endeavour. That is why I would urge up-front, one-time investment to ensure successful implementation.

A new, provincial, shared-services organization should be established to undertake supply-chain management and standardization at a provincial level.

Province-wide purchasing for major items such as radiology equipment and computer technology could yield significant savings to taxpayers. In addition, purchasing insurance and pooling short-term borrowing needs for all health regions and the Cancer Agency can save significant dollars. Over the past year, health regions collectively paid over $4 million in collective interest expense for short-term cash management. Therefore, it behoves the Ministry of Health and the health regions to explore financing options that will reduce interest expense significantly and direct savings to patient care programs.

Patients, staff, and members of the public questioned the effectiveness of the current regional model. Given the distractions that can result from structural and organizational change, I have not recommended revising the current regional model for the time being, although there should be a focused effort to improve the efficiency of the regions' corporate functions. It is important that the Government of Saskatchewan identify and consider options for broader change.

My view is that if one were to design a contemporary model for overseeing health care to one million citizens, there would be little chance that Saskatchewan's current model would be chosen. Should there be remodelling of health care in the province in the future, jurisdictions should be organized on the basis of patient flow, not arbitrarily determined geographical boundaries.

In order for the governing boards to effectively fulfill their stewardship role, members need skills that equip them for policy development, decision-making and organizational oversight.

While overall resourcing in the area of general administration is lower than that of other jurisdictions, there appears to be a higher proportion of dollars spent on the boards. This is a function of having numerous regions, each with a board of directors served by a senior management team. Over $1.7 million is spent annually on per diems and direct board costs to support all of the activities associated with regional governance. This does not include the thousands of hours the regions' management groups spend preparing for monthly board meetings, committee activity and special sessions.

Working within the existing regional governance model, several actions could be taken to reduce the expenditures associated with governance activity. *The Regional Health Services Act* provides for a maximum of 12 board members appointed to each health region board; this maximum number is typically observed. Through attrition, board membership could be reduced to seven directors, meeting a maximum of five times per year. Numerous former board members voiced concern about their role, indicating they were primarily involved in operational decisions rather than policy formulation. Examination of board meeting material supports this observation. Savings from reduced board costs should be reallocated to patient- and family-centred functions.

In order for the governing boards to effectively fulfill their stewardship role, members need skills that equip them for policy development, decision-making and organizational oversight. Effective corporate governance lies in the relationship between directors and in the competence, integrity and participation of individual directors. Formal board evaluation is critical to ensuring effectiveness, providing feedback on performance and creating a culture of "learning leaders" from the top down. A province-wide evaluation model should be adopted and board chairs should engage with appropriate experts in designing this model. An inclusive approach to developing this model provides valuable insights for the participants and fosters a province-wide perspective.

I suggest that all health region and Cancer Agency boards conduct annual performance reviews of their CEOs. The review should follow a template developed by board chairs in consultation with the Ministry which is based on the health system strategic directions, and should at a minimum, consider metrics that reflect quality, safety, and performance of the organization.

Commissioner's Recommendation:

14. **That the Ministry of Health achieve greater value for patients' tax dollars by establishing a provincial shared-services organization that would gain buying power and realize significant savings. This organization would initially be responsible for supply chain management (competitive tendering, procurement, storing, distribution, and payment), with the subsequent addition of responsibility for health regions' transactional business functions.**

Executive staff/medical staff partnership

Ineffective working relationships between physicians and their respective regional leadership are apparent in a number of health regions. This dysfunctionality was described by both patients and providers during interviews and some focus groups.

Unproductive relations between regional leaders and medical staff can adversely affect the workplace and, in turn, the delivery of quality care. Understanding the value of physician involvement when it comes to delivering accessible quality care is a critical factor to the success of meeting community health needs.

Without a solid base of mutuality and clear understanding between medical staff and executive leadership, service consolidations and program alignments may foster a win-lose mentality that damages mutual trust. In these circumstances, executive leadership and medical staff are both responsible for fostering an environment of partnership and collaboration.

For the sake of patients, there cannot be a dividing line between management and regional medical staff. A "we" and "they" philosophy must be superseded by an "us" philosophy that emphasizes working together for the benefit of the patient.

Only when medical staff perceive that regions are genuinely interested in engaging them will there be a constructive dialogue that promotes collaboration and builds mutual trust. Findings from the review indicate that physician leadership roles in non-urban regions are highly variable in terms of time commitment. Increased medical staff leadership is necessary in all regions to support change improvements and accountability requirements.

Catching up on capital

Saskatchewan's health care infrastructure assets owned by health regions, government, faith-based organizations and affiliated entities represent billions of dollars in investment.

Alternative financing partnerships present Saskatchewan's health care provider organizations with opportunities to access new sources of capital, expertise and technology.

In visiting numerous health care facilities and consulting with system leaders and care providers, it was my observation that capital infrastructure and related technology investments have been deferred for far too long. Years of neglect of building maintenance have resulted in accumulated deficiencies that have a huge price tag for taxpayers. The current physical decay of health care infrastructure will grow exponentially with the passing of time unless major remedies are instituted province-wide.

Saskatchewan's health care infrastructure includes elements that are in significant disrepair and, in some cases, are borderline compliant with current occupational health and safety standards. This leads to compromising the workplace environment and, in turn, the safety of patients and staff. Over the past decade, health care needs have dramatically changed. Regrettably, capital investments have not kept pace. Further, the provincial priorities have not reflected the need to build appropriate capacity to address shifting population and growing volumes of patient care.

All too often in the past, capital funding for health infrastructure has been erratic from year to year. To ensure safe, quality workplaces and patient comfort over the long term, I support a more predictable long-term capital financing plan.

In view of the insatiable appetite for replacement of health care infrastructure, and the pent-up technology demands, alternative funding mechanisms should be given serious consideration to refresh both buildings and technologies central to the delivery of quality care. Future major investments in diagnostic/treatment equipment, parking structures, and long-term care facilities are logical candidates for leasing or alternative funding mechanisms. The United Kingdom health care enterprise has led the way in adopting such mechanisms.

Patients and health care provider organizations look to the Ministry of Health to set out a vision and strategy that will guide the health system.

Alternative financing partnerships (AFPs) present Saskatchewan's health care provider organizations with opportunities to access new sources of capital, expertise, and technology. When designed properly, AFPs can play important roles in delivering public infrastructure projects on budget and on time while offering value for money to Saskatchewan taxpayers. These opportunities allow health care organizations to address the dual challenges of restricted public funding of the past, and the pent-up demand of years of neglect to refurbish fatigued capital assets. I strongly believe that successful partnerships require a planning framework, provincial strategy, and prudent selection of partners before the province embarks on such arrangements.

Alternative financing partnerships in health care are being pursued across Canada and in numerous countries around the world. Similar partnerships in Saskatchewan can offer new opportunities to facilitate the building of infrastructure such as new parkades or long-term care projects that meet the parameters of an AFP.

A coherent capital plan, which is currently in development with the health regions and the Cancer Agency, will represent progress. The framework for such a plan must be based on a provincial service delivery plan that is agreed to by the regions and under the direction of a dedicated Ministry branch. Planning principles should guide and inform the development of plans for each region and business cases must be prepared for each regional service delivery plan.

Commissioner's Recommendation:

15. That the Saskatchewan government explore ways and means to develop a coherent financing plan, including alternate financing partnerships, to address the urgent need for capital infrastructure investment.

A renewed role for the Ministry of Health

Saskatchewan's health care enterprise is complex and diffuse, and is confronted with numerous demands. Patients and health care provider organizations look to the Ministry of Health to set out a vision and strategy that will guide the health system.

The effectiveness of the interface between the Ministry of Health, health regions, the Cancer Agency, and SAHO is critical to delivering timely, quality, and sustainable care to Saskatchewan's one million citizens.

In a preferred health care setting, the Ministry of Health would concentrate on setting strategy, priorities, and standards of performance and monitor outcomes in a transparent manner to achieve public accountability. The ministry's leadership must be receptive to changing its modus operandi and portfolio structure so that all its influence and skills drive "system transformation" that will not only put the patient first, but will achieve improved performance.

The Ministry of Health would concentrate on setting strategy, priorities, and standards of performance and monitor outcomes in a transparent manner to achieve public accountability.

Only with this focused ministry direction will health care providers and system leaders regard themselves as true partners and think, plan, and act as a system. This new mode of interaction will result in a positive and productive working relationship. Equally important is achieving clarification on the roles and accountabilities of the regions, Cancer Agency, and the Ministry.

In response to patient and public concerns, it is important that this report offer advice on change improvements within the Ministry. The starting point is to examine the suitability of the current organizational structure relative to the Ministry's role, current challenges in the health system and future needs. The Ministry's organizational structure should be re-aligned to support a transformational change agenda outlined in this report. This will allow the ministry to more effectively serve its stakeholder constituencies by assuming more of a strategist-integrator-steward role for Saskatchewan health care.

Significant concerns have been raised about the mechanisms used to monitor compliance with the Ministry's service delivery and performance expectations. I am encouraged by the work that is under way to streamline the accountability agreements between the Ministry and its service delivery organizations, and urge the partners to continue to work together to arrive at an agreement. A few vital performance measures should be articulated, and consequences of non-compliance should be identified.

Financial metrics that track and record utilization of resources, budget performance against targets, operational efficiencies and workforce-related benchmarks such as sick time, Workers Compensation Board charges/rebates are all important matters that should be publicly and transparently reported.

The current regional model, adopted in 1993 and amended in 2002, presents many challenges for the Ministry as it pursues ways and means to best support each region. Meanwhile, all other provinces have moved on from their original governance models to achieve better performance and improved quality. In the long run, preserving the status quo in Saskatchewan will not yield the quality outcomes and system efficiencies expected by patients and taxpayers alike.

Commissioner's Recommendation:

16. That the Ministry of Health move forward with organizational changes that will enable it to assume more of a strategist-integrator-steward role for the health system.

Strong leaders and accountability to the public

I do not underestimate the challenge of leading transformational change in health care. The system is inexperienced in this regard. Aside from the introduction of Medicare and regionalization, health care can be characterized by either status quo increases (more of the same) or incremental, isolated developments focused on specific parts of the system. Often these incremental changes to improve one part of the system have had unintended consequences for another. It will be difficult to advance changes that lead to a patient focused health system and it will require strong resolve and courage on the part of policy makers, health professionals, decision makers and senior leaders.

The challenge of leading transformational change ... will require strong resolve and courage on the part of policy makers, health professionals, decision makers and senior leaders.

The challenges ahead require nothing less than a highly skilled and committed leadership that inspire and empower the health care workforce. I heard from frontline providers and patients alike who raised concerns about the lack of visible senior leadership. Leaders and managers were not seen as connected to the "everyday business" of health care and in some instances the roles of managers were unclear and duplicative. The engagement of senior leaders with staff at all levels of the organization is necessary to drive the transformation of the care and caring experience. The engagement of leaders with patients is also important. In addition to natural attrition, it can be expected that a number of people in key positions will retire over the next few years. Health regions, the Cancer Agency and the Ministry need to ensure readiness by engaging in succession planning now.

Accountability is fundamental to effecting change and is closely connected to leadership. Results-oriented organizations require clear accountability relationships, defined performance measures, and well-defined mechanisms for ensuring targets are met.

The public is interested in increased transparency in health care and it is important that information is provided in areas such as health outcomes, patient safety, wound prevalence, infection rates, and adverse patient events, and system performance indicators. More transparent, timely and robust public reporting on system performance would be welcomed by the public.

Conclusion

From its outset, the mandate of the Patient First Review was to seek out ways to improve patient care and its administration in Saskatchewan. As a result, this report necessarily focuses on some of the gaps that have emerged or widened within the province's health system over time. The concerns we heard from patients and providers alike were real and expressed with an urgency for real change. It was important, then, that those concerns be expressed with a similar urgency in this report.

At the same time, it is worth noting here that every day, thousands of health care providers go to work with the hope and intent of providing excellent care. Yet health care is an incredibly demanding field in which to build a career, and for those who spend their days interacting with people who are ill, injured, and often under great stress, the demands can sometimes be overwhelming, particularly in a workplace that may be cramped, aging, or ill-equipped for today's challenges. I was privileged to meet with some of these unsung heroes and hear them speak with passion and eloquence about their own desire to deliver patient- and family-centred care, and some of the barriers they were experiencing. We now owe it to them to empower them and give them the tools that will enable them to provide the care they were trained to give – and want to give.

While there are obvious challenges associated with the affordability of the latest medical and diagnostic technologies, a great deal can be done to optimize the health care dollars that directly affect and improve patient care. By moving from a piecemeal array of services, service providers, and systems to an integrated provincial network, Saskatchewan can gain significantly greater value for the money its taxpayers contribute to health care.

Saskatchewan people do not appear to be calling for a thorough dismantling or fundamental re-invention of their health system. They recognize the system's relative strengths and are proud of the Medicare legacy. However, they also want to see real "fixes" to those issues that persistently contribute to poor access and a poor health care experience.

Saskatchewan people do not appear to be calling for a thorough dismantling or fundamental re-invention of their health system.... However, they also want to see real "fixes" to those issues that persistently contribute to poor access and a poor health care experience.

Saskatchewan does not lack individuals with tremendous ideas and energy, leaders in patient care and in administration who have the talent and the vision to build a revitalized, patient-centred health system. Nor is there any lack of patient- and family-centred models that have been adopted and adapted in other jurisdictions with great success.

Significant change does not happen, of course, without significant investment of time, effort, and fiscal and human resources. Before embarking on transformational change, the Ministry of Health, with its partners in the Saskatchewan health care enterprise, will need to determine both the relative costs and the relative priorities of the recommendations contained in this report.

With any change to the established and habitual ways of operating, there will be resistance from those more interested in preserving the status quo than responding to the voices of patients and their families. A passion for quality, a willingness to innovate, and the ability to collaborate will be requisites for Saskatchewan's health system leaders.

Saskatchewan has the people and the knowledge necessary to achieve excellence in health care. What is needed is the collective will and vision to bring about real change. The provincial government will not succeed on its own, nor will any one health region, physician, care provider, manager or patient advocate.

Patient First must become more than a mantra. For the sake of patients, it must become a movement that is embraced by all who have a stake in creating healthier communities.

Endnotes

1 Canadian Institute for Health Information. *National Health Expenditure Trends 1975-2008*

2 McGlynn, E.A., S.M. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E.A. Kerr (2003) "The quality of health care delivered to adults in the United States," *New England Journal of Medicine* 348(26):2635-45, found that only 56 per cent of adults with chronic diseases receive guideline-recommended care. Diabetes, a serious problem in Saskatchewan, was the worst managed condition. Consistent with this finding, Saskatchewan's Health Quality Council (HQC) recently reported more than half of people living with diabetes in Saskatchewan do not maintain their blood sugar or cholesterol at optimal levels.

3 For example, despite the proven life-saving efficacy of beta-blockers, statins and ACE-inhibitors for preventing further heart attacks in post-acute myocardial infraction patients, the HQC reported that only 42 per cent of Saskatchewan's heart attack patients had filled prescriptions for all three recommended medications within 90 days of leaving hospital (*Quality Insights: Measuring. Learning. Improving Health Care Together*, 2008).

4 For example, the HQC recently reported that among community-dwelling seniors who were chronically dispensed benzodiazepines (a medication used to treat anxiety and insomnia), more than 1 in 5 received dosages higher than the recommended maximum for seniors. This rate increased (indicating poorer quality of care) by 3% between 2003/04 and 2005/06 (rising from 20% to 23%) (*Quality Insights: Measuring. Learning. Improving Health Care Together*, 2008).

5 Baker GR, Norton PG, Flintoft V, et al. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ*,170:1678–86

6 K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007

7 For the full terms of reference for the Patient First Review, please see Appendix B.

8 Transforming Your Practice: What Matters Most, Katherine Gottlieb, MBA, Ileen Sylvester, MBA, and Douglas Eby, MD, MPH, Family Practice Medicine, www.aafp.org/fpm, January 2008, pp. 32 - 38

9 Statistics Canada. *Population Projection for Canada, Provinces and Territories 2005-2031.* Cat. 91-520-XIE

10 Statistics Canada. *Projection of Aboriginal population, Canada, Provinces and Territories 2001-2017.* Cat. 91-547-XIE

11 The impact of unintentional injury in Saskatchewan is significant. Safe Saskatchewan reports the province's injury hospitalization rate is twice the national average and its death rate, at over 300 fatal injuries per year, is 1.4 times higher. Even though Saskatchewan's population is only three per cent of Canada's total, the number of unintentional injuries that occur here are nearly seven per cent of all injuries in Canada.

12 In 2004, Saskatchewan Health, in collaboration with other stakeholders, released a population health promotion strategy called *Healthier Places to Live Work and Play*. The strategy builds on work already underway in health promotion and disease and injury prevention, and challenges the health system and community partners to create environments where citizens find it easier to make healthy choices. Four priority issues were identified in the strategy: mental well being; accessible, nutritious food; decreased substance use and abuse; and active communities.

13 http://www.nytimes.com/2009/06/04/health/04chen.html

14 2009 award of excellence for interdisciplinary community services, Tommy Douglas Celebration of Medicare Awards.

15 Commitment to Care: Nurse Recruitment and Retention in Saskatchewan

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Appendix A

Consultations / Meetings

Throughout the course of the Patient First Review, many individuals and organizations took the time to contribute their stories and opinions, as well as feedback on the preliminary findings of the research. I appreciate the time and attention given by those who participated in the research focus groups, interviews, and meetings. Your contribution to the Patient First Review is immeasurable. In addition, I want to thank the following with whom I met outside the formal research process:

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Alvarez, Richard – President and Chief Executive Officer, Canada Health Infoway

Antosh, Susan – President & Chief Executive Officer, Saskatchewan Association of Health Organizations (SAHO)

Botting, Dale – Chief Executive Officer, Enterprise Saskatchewan

Bourassa, Richard – Saskatoon Surgi Centre

Bowen, Francis M.D. – Director of Emergency Department

Brossart, Bonnie – Health Quality Council

Brunskill, Donna – Executive Director, Saskatchewan Registered Nurses' Association

College of Physicians and Surgeons of Saskatchewan

Council of CEOs – Regional Health Authorities

Cummings, Donald – Emergency Medical Services Review

Davies, Maura – Chief Executive Officer/President, Saskatoon Health Region

Davis, Donna – Patients for Patient Safety Canada

Davis, Judy – Hospitals of Regina Foundation

Degelman, Bob and Dianne – City of Melfort

Dickson, Gary – Information and Privacy Commissioner

Earle, Allan – President, Saskatchewan Urban Municipalities Association (SUMA)

Fenwick, Kevin – Ombudsman Saskatchewan

Fox, Harvey – Former health sector Chief Executive Officer

Gardiner, Nap – Coordinator, Northern Health Strategy

Gibson, Dave – Director, Continuing Care and Seniors Health, Saskatoon Health Region

Hambly, Barb – VP, Alberta Health

Health & Social Development Commission, Federation of Saskatchewan Indian Nations (FSIN)

Heaton, Gill – Director of Patient Services/Chief Nurse, National Health Service, United Kingdom

Higgins, Mike – Vice President Human Resources – Regina Qu'Appelle Health Region

Hope Cancer Centre

Hornell, Jim – Cypress Regional Health Authority/ Community Leadership Network

Hospitals of Regina Foundation

Hunt, Cecile – Chief Executive Officer, Prince Albert Parkland Health Region

Irwin, Scott – Catholic Health Ministry of Saskatchewan (Saskatchewan Catholic Health Corporation)

Junor, Judy – MLA

Karasin, Keith – Canadian Cancer Society

Kendel, Dennis M.D. – College of Physicians and Surgeons of Saskatchewan

Kirwan, Joe – Chief Executive Officer, Sunrise Health Region

Knelsen, Karen – Provincial Affiliate Resource Group

Landry, Shan – VP Home Care and Long-Term Care, Saskatoon Health Region

Larrivee, Diane – Vice President Specialty Care – Pasqua Hospital

McMillan, Stewart M.D. – Chairperson, Saskatchewan Cancer Agency

Métis Nation - Saskatchewan – Métis Nation Roundtable

Memorandum of Understanding (MOU) on First Nations Health & Well-Being Steering Committee

Morrison, Jean – Chief Executive Officer, St. Paul's Hospital

Mougeot, Laurent – Chief Executive Officer, Saskatchewan Urban Municipalities Association (SUMA)

Mycyk, Taras M.D. – Head of Cardiovascular Surgery, Royal University Hospital, Saskatoon

Nelson, Dwight – President and Chief Executive Officer, Regina Qu'Appelle Health Region

Nilson, John MLA

Ouellet, Robert M.D. – Canadian Medical Association

Peterson, Glenn – Saskatoon

Popkin, David M.D. – Vice-President, Care Services Clinical, Saskatchewan Cancer Agency

Prince Albert Chamber of Commerce

Quality of Care Coordinators and Patient Navigators – Regional Health Authorities

Ross, Laura – MLA, Legislative Secretary for Nursing Recruitment and Retention

Ryan, Shirley – Saskatoon Business Association

Saskatchewan Medical Association Board of Directors

Sharma, Nawal M.D.

Shaw, Mike – Ministry of Government Services

Schriemer, Joceline MLA – Legislative Secretary to the Premier, At-Risk Youth Initiative (formerly Legislative Secretary for Addictions)

Stefiuk, Donald M.D. – Saskatoon Regional Medical Association

Stephanson, Randy – Regina Qu'Appelle Health Region

Stromberg, Bonnie – Lawyer

Taylor, Len – MLA

Vail, Stephen – Director of Research, Canadian Medical Association

Vogel, Martin M.D. – Executive Director, Saskatchewan Medical Association

Vuksic, Chris M.D. – Senior Medical Officer, Regina Qu'Appelle Health Region

Appendix B

Patient First Review: Terms of Reference

Introduction

Government committed to a Patient First Review of the health care system, that, with input from health care stakeholders would:

- improve front-line care for patients;
- direct dollars away from bureaucracy to front-line care; and,
- create quality work environments for health care professionals.

We want to improve our health care system in ways that are meaningful for patients. It is important that we involve both those that receive and those that deliver health care.

Who Will Conduct the Review?

Tony Dagnone has been appointed Commissioner and will provide oversight and general management to the review. KPMG LLP and Deloitte Inc. are firms that have experience in working with health care systems and are each conducting parts of this review.

Mandate of the Commissioner

1. To undertake consultations with patients that are focused on the patient experience with health care. Using a range of mechanisms, the consultations will solicit information on what is and isn't working well in the health care system;
2. To undertake consultations with health care providers and stakeholders, which examine the feedback from the patient consultations and identify opportunities to improve patient experiences across the continuum of care;
3. To provide a report to the Minister that includes findings from the consultations with patients, providers and stakeholders, and makes recommendations on changes needed; and
4. To complete an administrative review of the Regional Health Authorities (RHAs), affiliate organizations, and the Saskatchewan Association of Health Organizations (SAHO) to assist in determining the overall effectiveness of resource use in the health sector, by identifying the current base of administration, operating efficiencies, constraints and opportunities for improvement, and to provide a report to the Minister of Health.

Principles

The review will be conducted in accordance with the following principles:

Patient-Centered – The review will support a system-wide focus on improving patient/public care and experience.

Open – The review process will engage the public through multiple avenues and will be open to receiving and considering new information.

Transparent – The review process will be open to public scrutiny, and the results of the review will be available to all Saskatchewan residents.

Innovative – Ideas for change and innovation will be welcomed from the public, stakeholder groups, and health care experts. Experiences in other jurisdictions will be examined.

Accountable – The results of the review will demonstrate responsiveness to input received and a commitment to building a health care system that puts the patient first.

Patient First

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Saskatchewan
Ministry of
Health

The Need for More Effective Patient- and Family-centred Care

Report on the patient experience component of the Saskatchewan Patient First Review

Prepared by KPMG

October 2009

PatientFirst

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1. Summary Report Overview

The enclosed report provides a summary of the research, findings and recommendations captured from the conduct of the Patient Experience component of the Patient First Review. The Government of Saskatchewan commissioned KPMG to manage the patient experience research. This report reflects a summarized version of the detailed report, which provides the research team's complete findings and recommendations.

The detailed report can be found online at www.health.gov.sk.ca/patient-first-review .

2. Introduction

"Is this the best we can do?" That is the core question driving the Patient First Review. Canadian governments have asked this question before, from the perspective of clinical outcomes or economic value for money, but never from the perspective of the patient.

In fact, the Patient First Review has split that basic question into two:

- Can we do better for patients?
- Can we get better value for the dollar in the health administrative services to free up more resources for health delivery?

The Patient Experience component of the Patient First Review looked to answer the first of these two fundamental questions by seeking the input of patients, health care providers and stakeholders on what the actual patient journey is like in Saskatchewan and what can be done to make it better.

Participation from patients, providers and stakeholders in the Patient Experience component of the Review was enthusiastic. Over 4,000 responses were collected across the four phases of the research. Just over 2,500 people participated in the initial patient experience consultation (Phase 1). Just over 500 health care providers and ancillary staff participated in the various provider consultations (Phase 2). 82 stakeholder representatives participated in the three stakeholder sessions and 168 workbooks were completed in the stakeholder consultation phase of the research (Phase 3). Finally, 1,076 Saskatchewan residents completed a random telephone survey.

The extensive process to collect and respond to the patient perspective has forced the Patient First Review team to challenge our assumptions and think outside the box. The patient voice has left the Review with some unique conclusions that set the Patient First Review apart from previous studies.

Placing patients first adds important dimensions to how we judge the success or failure of the health care system.

Patients received both the first and last word in this Review. Patients spoke first through the Phase 1 patient experience consultations and they wrapped up the consultations in the random telephone survey. Their personal stories brought into focus the human price too many patients are paying because of problems in the system today. By putting patients first, we heard the health care system judged not in terms of productivity or efficiency or even clinical outcomes, but in terms of pain, suffering, worry and fear.

> *"I've had a couple of my surgeries cancelled due to NO beds available after my surgery. I would have had to stay for 10 days and there were no beds. So I had to wait for 6 more months. Not pleasant with my illness. I was in constant pain and lost over 70 pounds. Then 2 times I sat in my hospital gown, fasting since the night before and it wasn't until 5:30 pm that I was told it was cancelled because an emergency surgery was being performed and the other time the emergency room was busy, so there was no bed for me. That made me mad!"*
> *(Patient)*

Success was not measured in dollars per case or length of stay, but through relief, joy, peace of mind and confidence. Too often health care is considered only in terms of its monetary costs, but this report is founded on the human price and benefits.

> *"A couple of nurses went out of their way to help, and REALLY LISTEN to our concerns, and answer our questions. I actually made a list of my questions at one point, and was able to persuade the nurse to bring the chart into the room and take all the time needed to answer each question. After she left, the other patient in the room even remarked about how good that nurse was, to spend the time to actually answer all those questions and explain things!"*
> *(Patient)*

Navigation and coordination failures are key drivers of fear and anxiety

One key finding related to this new perspective is the importance of navigation and coordination in the health care system. A journey through the system can be a terrifying experience. The terror most often comes not from what any provider does or says, but from uncertainty and fear of the unknown.

> *"If you feel like you can't breathe it's the scariest thing in the world. When I arrived at the hospital there wasn't a seat to be had. I asked the lady there - I'm not sure if she was a nurse or what she was - if I could go to another hospital. She said it wouldn't be long but she didn't tell me how long it would be. She gave me some forms to fill out but I told her I couldn't do them right away because I thought I was having a*

heart attack. I had to sit on the floor because I didn't have strength. I just curled up on the floor. They finally took me in after about forty minutes or so of me just sitting there, slumped on the floor, feeling like I couldn't breathe. It was so frightening. "
(Patient)

Again and again stories about patients' negative experiences involved their inability to navigate particular parts of their health journey or in the failure of the system to provide the patient with one individual who works regularly with the patient and keeps track of the patient's health challenges and the system's various responses. The Patient First Review Province-wide telephone survey shows that almost half of Saskatchewan residents are worried that the health care system is so complex that they won't be able to find the help they need. Those people who are not confident in their ability to find the care they need are much more likely to give the health care they receive a low grade. In some cases those who are not confident are twice as likely to give a negative score as those who are confident in their ability to navigate the system.

"It can be very difficult when you are sick to take control of all of your appointments and what you need to do, especially if you are not used to it. You need someone to help you. You basically have to be a doctor to navigate your way through the health care system here in Saskatchewan!"
(Patient)

"There is no follow up, there are so many people who are alone and have nobody, and there are so many people who need support, they just need somebody to check on them."
(Patient)

Contrast those experiences with the ones below which shows for some people the ideal health care system is right here and now in Saskatchewan.

"I really like that my family doctor is not only my doctor, but also my kids' doctor. It means that I only have to go see one. If I have a question about myself in the middle of my kids' appointments, I can ask that question. And it's great because they know who you are; my doctor always remembers us and asks different things about my kids even though they aren't always there. It just shows that she really cares, and that is nice."
(Patient)

"I would credit my cancer care to my family doctor. She had a good chain of communication and contacts. After finding the lump we moved very quickly through the health care system. I felt that everything was under control."
(Patient)

Unfortunately, for too many people, the story of one regular doctor who knows and cares for your whole family and navigates the system for you is still a dream. Yet many positive experiences highlighted the role of a health provider, often a family doctor, who went out of his or her way to make connections and undertake follow-ups to ensure that patients received the care they needed, when they needed it. We recognize that with primary care reform in progress, the key primary care navigator may not be a doctor, but that is the reality for the average Saskatchewan patient today.

The critical importance of primary care to managing health care transitions is highlighted in the Patient First Province-wide telephone survey. More than half the problems with transitions from one part of the system to another start when patients are leaving primary care. Generally they are transferring to a specialist doctor or for diagnostic testing. Organizations such as hospitals with discharging planning systems or 'most responsible' physicians can't help solve these problems because they are not part of the process in many cases.

This question of navigation and co-ordination is already on the health system's radar screen when it talks about electronic health records, primary care reform, discharge planning or cancer patient advocates. But these initiatives take on a whole new level of urgency when we consider the price patients and their families pay everyday in fear alone.

We will not see a permanent change in the patient experience if we keep running the system the same way we always have.

This is hardly a new insight. After all Albert Einstein said "Insanity is doing the same thing over and over and expecting different results" as well as "We can't solve problems by using the same kind of thinking we used when we created them". The patient story is of paramount importance to health care planning. The metrics that are currently used to plan and manage the system include clinical outcomes, budgets, and occasionally, surveys. But pain and suffering, relief and peace of mind don't lend themselves to quarterly updates and annual plans.

We not only have to change what we are doing, we have to change how we are doing it. What is required is a fundamental change in culture and processes. We won't get one without the other.

The transformation will not be complete until providers talk about patients as people they work with, not people they work on.

Collaboration is a key principle that Saskatchewan's health leadership appears to have embraced, but it remains to be fully implemented. The traditional health care administrative model is a top down, leadership driven approach that drives a one size fits all delivery system.

> *"My mother said to me after seeing her doctor, "I don't think he hears me when I talk." She doesn't feel looked after."*
> *(Patient)*

> *"Doctors just don't listen to you. The difference between God and the doctors in this Province is that God doesn't pretend to be a doctor."*
> *(Patient)*

That model will not allow the system to deliver individualized care and is de-motivating for providers as well.

Saskatchewan is already moving towards a more collaborative approach both in terms of planning for a cultural shift that focuses on value to the customer and eliminating waste by applying approaches such as Lean, and in health delivery in initiatives such as primary care reform. However, while it is good that the system is moving towards more collaborative models between policy makers, managers and providers, we can't stop there. The system will not become more patient-centred unless the process of planning and managing involves patients.

> *"Up until the last 18 months of my life I have always been an extremely healthy person and I have rarely had to access the health system. I always regarded the health care system with pride and trust and good faith. I felt assured and assumed that the care, should I ever need it, would be nothing less than the best. However, my past experience over the last 18 months or so has proven to me how naive I was. Not only has my experience opened my eyes to the realities of our system, but it has caused me to be extremely apprehensive about accessing the health care system and any future care I might receive. I realize there are no easy answers to the problems that face our health care however that is no excuse for what exists now. Over the past 18 months I have felt extremely frustrated. I was a patient but I did not have a voice. Things were happening to me that I could not control and I felt that I had no active part in that process neither was it encouraged or welcomed. I was very happy when I heard about this survey because it made me feel like I would finally have a chance to have a "voice" that would allow me to express my concerns I have had regarding my experience. My hope is that this survey will result in some positive changes for our health care system. It is needed."*
> *(Patient)*

This patient is not unique. Consumerism is growing in health care. Consumerism is a trend of changing patient-provider relations where patients expect to be treated with the same level of care and deference that marks the best consumer marketplace experiences. Patients who are high in consumerism expect timely care and responsive answers to their questions. Patients who are low in consumerism defer to their main caregiver's advice; those high in consumerism often seek alternative information and advice. In this survey, we have included one statement that covers the deference dimension of consumerism, "I like to do my own research before I take my doctor's advice". More than half (56%) of all patients agree with the statement. While some patients remain deferential, a majority expect to be major decision-makers in their own care and 1-in-5 passionately hold that belief. Not surprising given stories such as the one above, people who hold consumerist views are less satisfied with the current system than those who are more deferential. However, it is important to note that a high level of consumerism is a less powerful driver of system approval than low levels of confidence in system navigation.

In the evaluation of other systems moving towards a patient-centred approach, it is clear that the active engagement of patients in planning and delivery is key to the transformation. Structurally, that means the engagement of patients on a routine basis on any planning exercise within the sector as well as the development of new accountability tools. Culturally, it means that providers need to look at patients as partners in their care plan and in decision-making.

Every dollar spent on administrative overheads must be justified against its potential use in buying improvements in patient services.

Participants in the review generated a number of ideas for improvements that involve better use of existing resources, but there is no question that significant improvement in service will require additional resources. The first place to look for those needed resources should be the money already committed to health care.

On the clinical side, that process has begun with moves toward a cultural shift known as Lean. That type of review has enjoyed wide support among provider groups and is building momentum in its application within the health care system.

> *"I am a big supporter of Lean. You have to eliminate inefficiencies and waste – everything needs to bring value for the patient."*
> *(Health care provider)*

We need to bring the same approach to administration. Let us be clear, we recognize that administrative functions such as supply chain management, human resources, information technology and general administration are critical supports to front line workers. We all need to appreciate the contributions made by people in those functions. But like every aspect of the system, we need to challenge past practice and ask ourselves if we can't do better, if there is not some way we can get more value out of our existing budget and free up funding to buy change.

3. What Are Patients Looking For?

What do we mean when we talk about change for the better?

In the first phase of the Patient Experience component of the Review, we explored how members of the public experience the health care system, through an online and mail-back workbook (2,247 participants) that was open to everyone in Saskatchewan. The public also participated in the process through randomly selected qualitative research conducted in one-on-one, small group or large group consultations, as appropriate. The experiences gathered from this process were checked and confirmed in the second stage of research with providers where 413 providers shared their views through an online and mail back workbook, and 94 providers participated in a series of 10 focus groups across the Province.

Both patients and providers were given the opportunity to provide input on three key research questions:

1. What has been your experience in the Saskatchewan health care system?
2. What are the key factors that you feel drive that experience?
3. What ideas would you suggest to ensure good experiences are sustained and bad experiences are avoided?

Not only did the negative patient experience stories show what needs to be improved, the positive stories helped us understand the system that patients want. There is one basic consideration that is the minimum commitment patients require from the system – error free medicine. While patients understand health care is delivered by people and people make mistakes, nothing will more quickly raise the public's ire than a story of delayed or mistaken diagnosis. We will return to this theme shortly. But what does the system need to do to rise above the acceptable?

The patient-centred system Saskatchewan patients want has five key characteristics:

1. Fast access to needed services
2. Effective case management and coordination
3. Good two-way communications
4. Providers who show they care
5. Recognition of the unique needs of underserved populations and regions

In the following pages, we illustrate those priorities both by looking at what is missing from negative experiences as well as looking at what is driving the positive experiences. To be clear, the future we want can already be seen in the many examples of positive experiences patients shared. But the areas for improvement can be seen even more starkly in the negative experiences we show beside each positive experience.

Lack of access or delayed access to needed services versus fast access to needed services

A patient-centred system will provide patients with fast access to the services they need from the start of their journey to the end. Patients with negative experiences often report limited access to a variety of services starting with family doctors or alternative primary care services (including home care), emergency or urgent care and access to specialized care including access to specialists, diagnostics, long term care, mental health services and addiction services. In addition, when services are available, patients frequently report extensive wait times to access the available services. These delays can be measured in hours for treatment in ER, in months for diagnostic services, and in years for some surgeries. On average 3-in-10 recent patient experiences generate poor or very poor approval ratings in the Patient First Province-wide telephone survey. Mentions of reduced waiting times or staffing and capacity increases dominate suggestions for improvements. Access is the dominant concern of patients.

FAST ACCESS TO NEEDED SERVICES	
Positive	**Negative**
"I knew the doctor and he was able to get me in for my knee operation. The nurses were excellent, the operation was not an overnight stay and it was able to be done within an hour of my home. I was able to get in for the operation in a reasonable length of time - about six months - and best of all the operation greatly reduced my pain."	*"I am on a waiting list for a knee replacement, and have phoned the Health Region, and talked with my local doctors, but cannot get a consistent date of when my surgery will be. I live alone on a farm, and it is limiting my ability to get around. I tell my doctor this but it doesn't help as he blames the Health Region. When I phone the Health Region, the lady answering the phone blames the doctors and nurses. It is confusing, and they just shift the blame rather than getting to the root of the problem and letting people know what is actually going on. I have said my complaint to the Patient Advocate, but this also has not helped. I am frustrated, and would have had new knees by now if I had just gone to Alberta and paid for it."*
"I went to emergency on a Friday with severe pain, saw a surgeon very quickly, had a CT scan, was diagnosed with ovarian cancer, was admitted by midnight, saw a specialist on Monday, surgery on Wednesday - very speedy service."	*"My wife has cervical cancer. It was diagnosed in 2005. The family Doctor she had before the cancer was found did not find the problem. The wife went back when she was in a lot of pain. The Doctor put her on pills for pain. He told her to come back when done. The pain in her legs and back were getting worse. Then the Doctor told her it was her back and she needed orthopedic shoes and said she was going to send her to a Back Specialist, which took 5 months to get in and see. This Doctor, when she did get in said that there was nothing wrong with her back. Back to her family Doctor, more pills. Then one night pain was so bad she went to the Hospital. She got to see an Oncologist. Did some tests and was sent home. Went to the Oncologist office and was told about the cancer. But was told if it was found out a few months earlier it could have been taken care of."*
"Again the system has worked for me, I have a wonderful doctor and when I was needing to seek help from a psychiatrist, I was able to see an excellent practitioner and I have benefited immensely from this. The response was timely and I have since recovered."	*"I have been extremely disappointed with the Mental Health system in Saskatchewan. We moved here from Ontario where we had an excellent family doctor and a wonderful Cognitive Psychologist to provide excellent medical care. When we asked one of our first family doctors here about a cognitive psychologist, he replied "A what?". This does not inspire confidence. The family doctor that we are currently with seems to be willing to at least put a little effort into the process and prescribed an additional anti-depressant and then referred my husband to a psychiatrist. But when we received the phone call to set up an appointment, we were told it was a nine-month wait list."*

Feeling lost in the system, or poor case management, versus being connected to the system

A patient-centred system will give patients a clear sense of confidence as to where they are in their health journey and who is looking out for them. Many patients who report negative experiences encounter poor transitions across health delivery silos or experience health conditions that require care from multiple providers where information and/or treatments are poorly coordinated. As a result, they can receive confusing or conflicting directives and often there appears to be no one in charge or aware of the patient's total health experience. The Patient First Province-wide telephone survey shows almost half of the Province doubts their ability to find the health care they need. Those people judge the system far more harshly than those who are confident. The results also show 1-in-5 patient experiences generate poor or very poor ratings for transitions between service silos while 1-in-8 cases generates poor or very poor ratings in staff communications of next steps. Better case management by all its names is a critical goal every way we look at it.

EFFECTIVE CASE MANAGEMENT AND COORDINATION	
Positive	**Negative**
"I have some problems with my knees and my doctor was able to get me into a trial at the Kinesiology centre that worked with people to evaluate conditions prior to having to see a specialist. This saved the time of the specialist as well as was able to resolve my problem quicker."	*"I have lower back problems so I asked my doctor what my options are beyond pain killers. My Doctor wasn't very helpful and just said there is nothing she can really do to stop the deterioration before surgery. And we don't know if I'll need that. I just wanted a second opinion but she was so eager to just prescribe pain medications – and she refused to listen. I'm reluctant to take the pain medication because they don't agree with me and they are very addictive. I just want to know if there are specific back doctors that I can go to."*
"My mother has Alzheimer's and the health care workers are generally kind and patient. I had an amazing Home care co-coordinator - I think it's SWADD - who advocated so well on behalf of me and my mother - and father when he was alive."	*"I have two boys with autism and there is no coordination of autism services in this province. That is a key factor in making our experience with the health care system negative. Lack of case coordination forces parents to become case managers for their children. It forces us, on top of all the care required for our children, to read and learn as much as we can about autism and the many, many facets of the disorder. We run the risk of being influenced by quacks with unscientific remedies. We need case managers who have an expertise and background in autism to help us understand what kinds of services may help with the behaviours or physical problems. Our children have mobility issues, sensory issues, sleep issues, communication issues, daily living skill issues, nutrition issues and more. We live with our children 24 hours a day and when they are struggling, we need support and education to learn how to possibly prevent the behaviours, we need help to keep our families together, we need to learn how to communicate with our children, we need experts to suggest ways to manage the problems that we face every day."*
"The care was immediate and consistent throughout my husband's emergency. After his surgery, the follow-up was excellent. The information provided by the emergency room nurses and clerks was thorough and the compassion was genuine."	*"I was ill-prepared for my surgery, due to my physician not informing me of the overnight stay and the recuperation period (4-6 weeks off from work and a 2 ½ week back to work program implemented by my employer, to accommodate me, on short notice). Post-surgery I was catheterized without being informed prior to surgery and upon awaking from anesthetic was startled to find the tube that I had tugged almost fully out and had to be put back in. I have been told by many friends, family and co-workers that they were not fully informed on the details of surgery and recouping time."*
"There is a diabetes collaborative in place in my community. Access to lab services for A1C testing is quick. We have nurse educators to assist in care if needed."	*"My community has a large diabetic population and they do not have a dialysis service here so patients have to travel to Saskatoon to receive treatment. Some cannot afford the extra cost of travel and food."*

Poor communications and dismissive attitudes versus good two-way physician-patient communications

A patient-centred system will ensure patients not only have their questions answered quickly and thoroughly, but will take the initiative to provide the information a patient may need even if they are not yet aware of that need. Many current negative experiences involve patients who can not get their questions answered, receive answers that are in complex or in otherwise hard to understand language, receive inconsistent answers or experience rude or abusive behaviour. Language barriers are also a challenge, both with patients who are not fluent in English as well as with providers for whom English is a second language. The Patient First Province-wide telephone survey found 3-in-10 patients have experienced unacceptable behaviour with First Nations and Métis experience at 45%. Improved patient-provider interactions are the second most common open-ended suggestion for improvement in the survey. This is clearly a major priority for patients.

GOOD TWO-WAY COMMUNICATION	
Positive	**Negative**
"My experience with a specialist was positive. I had had to do a lot of my own education about managing after my incident because it was a month from the incident (which occurred out-of-province) to my appointment with the specialist. When I did see him, I was able to discuss my concerns about a number of aspects of managing my condition, discuss my goals, and receive the kind of specific guidelines I needed to return to normal. He listened and respected what I had to say. He gave me his undivided attention and the time to learn enough about me to provide useful advice. Another positive was working with a nurse practitioner. Again, she listened and agreed to work with me to implement the plan I had discussed with the specialist. The other positive encounter has been with pharmacists. Thanks to them, I was alerted to potential dangers with my medications, side-effects which need to be reported, and lab work which is very important to do as long as I take a certain one. Their information was invaluable, as I did need to get medications changed."	*"I was diagnosed with a rare form of cancer. Passed around to several doctors, surgeons and oncologists. Then referred out of province. I felt like no one was responsible for my care. Follow up would be recommended but no one knew who was in charge of my care so it was never done. I found this out by getting a copy of my chart to ensure that I receive the appropriate follow up. I feel like the only one looking out for my care is me, however the health system is not "user friendly" for patients. For example, obtaining copies of my notes or radiology films usually involved several visits, signatures and sometimes requires me to get other health care people to request on my behalf. One department's release of information policies would be different than the rest. In my situation, I was going through the system on an urgent basis and did not have the time, energy or knowledge to be looking after my own care. There was also a lack of communication between facilities, departments, specialist, hospitals that made my care not very consistent."*
"[My doctor] is patient, understanding and very caring. He doesn't rush you through your appointment and helps us understand the process in which we are going and will be going. He is very thorough."	*"I always feel rushed through when I go see my family doctor. I am only allowed one problem per appointment and it makes me so frustrated because some things might be related. Doctors are too overbooked, they see too many patients. But if the alternative is not seeing me at all, I guess I'll take the partial care."*

(Table continued on next page)

GOOD TWO-WAY COMMUNICATION	
Positive	**Negative**
"We have been involved with home care and the geriatric assessment unit at the hospital for the last six months. There has not been a single negative situation during that time. My mother gets two baths per week. I have been present a couple of times when the home care Aides were working with my mother and they were fantastic. One lady was incredible, she helped us at every step and she was a wealth of information. Another home care Nurse was the same. With the general condition of the health care system in Saskatchewan, our experience with home care was very good. Thank You!"	*"When mother was in her final stages, home care came in to help with blood pressure checks. I appreciated their coming in, but my expectations were that they would know more than me about what's wrong and when we should go to the hospital and that sort of thing. But this person just did blood pressure, that's it. I didn't get a clue from the person to relieve questions and anxiety."*
"I was diagnosed with prostate cancer in June of 2008. I was referred to an excellent urologist who consulted with both myself and my wife and gave us very straight talk on my options - he also provided several books which confirmed what he told us. I opted for surgery and was put on a waiting list - I was called for surgery on Oct 1/08. The surgery went well, I received excellent nursing care and daily visits from my urologist. I was home after 5 - 6 days and am expecting full recovery."	*"I received notice on Dec. 4, 2008, that I am to have cataract surgery – at the end of March – a wait of 4 months. Then I received 2 letters from the Health Region OR Scheduling Office to call. I did call, and was informed the wait time would be 6-9 months. The letters state "If you have already been scheduled or have had your surgery, please disregard this letter." So here we have a scheduling office which doesn't know who is having surgery and who is not. And they tell me I have to wait 6-9 months. The doctor's office says "Disregard this nonsense. We do our own booking and scheduling, and we'll see you Mar. 31. Now, I want to know what this OR Scheduling Office is and why are we, as taxpayers, having to pay for it. Clearly, it serves no useful purpose, and seems to be working at odds with the surgeon's office. There is a difference between a 4 month wait and a 6-9 month wait. I tried to speak to the manager of this office, but he/she has never returned my call."*

Uncaring attitudes versus genuine caring attitudes

A patient-centred system will make sure that patients are treated with care and respect. All too often, negative experiences are driven by patient-provider interactions that leave patients feeling the provider doesn't care about them or is judging them and finding them wanting. Patients with an illness or injury are already experiencing tremendous fear and uncertainty. A smile and a kind word can make all the difference. In the extreme cases where discourtesy descends to rudeness or even abuse, the relationship of trust between a patient and his or her caregiver can be shattered and the resulting distrust can then impact the patient's health outcome. The vast majority of respondents to the Patient First Province-wide telephone survey agree "In general, health care workers in my community care about patients and treat them with respect" (89%). Yet despite that general belief, there are still regular incidences of specific communications breakdowns with 7% poor ratings for staff courteousness and 9% poor ratings for listening – leaving room for improvement even in this relatively strong area.

PROVIDERS WHO SHOW THEY CARE	
Positive	**Negative**
"I received immediate and compassionate care during several very difficult situations involving my reproductive health. The women who cared for me, the Dr, RN, unit clerks, even the women who worked at the information booth were very sincere, patient and calm ."	*"I was in the hospital having a pelvic exam when the obstetrician took a personal phone call while he was examining me. Here I am sitting with my legs in stirrups and his phone starts making a moo-ing sound or a rooster sound. The nurse was holding the phone up to his ear so he could chat while I was lying on the table in a compromised position."*
"I encountered many nurses, ambulance attendants, security personnel who were very compassionate in their care for me. I was paralyzed and unable to speak because of a brain tumor and my wife was beside me 24/7. She often received care and comfort from the staff in the form of warm blankets, bedside chair beds, and emotional support."	*"When you do go to the ER, it's almost like you are intruding on the nurse's time. They have their tasks they need to do, and they are always so busy doing their tasks that it's almost like a 'don't bug me, you are invading my space' attitude, which is very frustrating."*
"What was positive was the fact that the staff in the home where my mother was were understanding, updated daily on the patient's medical condition and are dedicated to making life comfortable for those in long term care."	*"My friend's son is in long-term care and it really bothers me because the way they dress him is so awful and disrespectful. They wouldn't go out on the street looking the way they dress him to look. I don't know why they don't try harder."*
"The programs at Four Directions Community Health Centre are good. It's good that you can walk in to most things like the Hepatitis C program with the nurse at the clinic. It's not judgmental and they remember you. You can also do cooking classes and things, which help if you're feeding kids and trying to stay healthy yourself."	*"I'm not sure if the nurse knew that I used to be a junkie but when she went to do the blood draw she said: 'I don't know why you need me. You know how to stick a needle in your arm.' Maybe it was supposed to be lighthearted, but nurses aren't supposed to talk like that to anyone. The sign that bothers me the most in the hospital is the one that says 'we will not tolerate any abuse – 0 tolerance'...but often when you leave, you are the ones who feels like you've been abused."*
"Our son was born with a heart defect. Our doctors were so great at looking after him. They prepared us and him. They spoke to him at his level and us at our level. It made all the difference and made us all more comfortable with what was happening."	*"I went to one specialist who kept referring to my two-year-old daughter as 'it'. When my husband corrected him, his response was "when you've been doing this for as long as I have, they are all 'it'." Last time I checked, my daughter was a human being, not an object."*

Recognizing the unique needs of under-served regions and populations

A patient-centred system will recognize the cultural and regional diversity of Saskatchewan and provide care in a manner that respects both distances and diversity. Some negative experiences, particular among First Nations and Métis, were driven or compounded by culturally inappropriate communications and outright racism. Other people living in remote and rural areas described feeling "forgotten" and heavily burdened by the need to travel great distances to access appropriate care for themselves and their families. Consistent with the findings from the discussion groups, the Patient First Province-wide telephone survey found that First Nations, Métis and residents of rural regions generally report lower satisfaction ratings than other groups, providing further support for this item.

Recognizing the Unique Needs of Underserved Populations and Regions	
Positive	**Negative**
"The Counselor was very understanding and could speak my own language which is Cree"	*"Elders have a hard time communicating with the medical staff at the facility. Elders can only speak Cree."*
"My mother-in-law had knee replacement surgery. Coming from a small northern community (she rarely leaves the community), she is not as comfortable speaking English, but everyone at the hospital was great."	*"Doctors do not speak in basic language when discussing the diagnosis with the elderly and non-educated people in my community. As a result, some do not understand their condition when leaving the hospital."*
"The Hospital has a spiritual room where I was allowed to participate in my cultural practices. I was pleased with my experience because the hospital asked which tribe I belonged to in an effort to identify the right Elder Tribal leader."	*"Now relating to the Cardiac Rehab program, I notice that it appears to be for white people only. No Aboriginal people there except myself. When I asked the staff about this, they said yes, the aboriginal people don't seem to come. And Cardiac Rehab is doing what to address this?? I also noted that in the Diabetes Education program that Aboriginal people do not come, either. This inequity needs to be addressed, especially with the numbers of aboriginal people with diabetes and heart disease."*
"I think there is good communication between doctors in this community (remote northern area) and the hospital in the city. My doctors in the city provide updates to the doctors here so that I don't have to explain things over and everyone knows what to do."	*"When you have to travel 3 hours to Saskatoon for tests and to see specialists it would be better if these appointments could be organized to cut down on travel expenses and to get quicker results. Most appointments need to be booked 6 weeks in advance. If some of these could be booked close together that would help. When you are sick and in pain 6 weeks is a long time. You start feeling like just a file in someone's desk that no one cares about and you are in pain 24/7."*
"Navigating access for long term care was difficult but with the assistance of our local family practice physician it was made easier."	*"My 89 year old father was placed in a nursing home 40 miles from his home – too far for his wife to visit him. He was put there because there was room – but no consideration was given to the fact that he was not going to have visitors because he was too far away. Initially he was to be put in one 150 miles away, until my sister kicked up a fuss. I know of 5 other people from 4 other health districts who were put in communities where they knew nobody and which were too far away for spouse, friends and family to visit. For instance one French speaking lady was put in a home in which all the elderly residents spoke Ukranian! Because there was room there. In another case, a Cree speaking woman from Cumberland House was put in a nursing home in Hudson Bay! I could go on and on."*

4. Getting Different Results by Doing Things Differently

If we keep running the health care system the way we always have, we can't expect to get different outcomes.

Three years ago the Province was shocked by the tribulations experienced by Baby Paige Hansen. After giving the Saskatchewan health care system three weeks to figure out what was wrong with their baby, the Hansen family finally drove to Edmonton where Paige was diagnosed with leukemia within 24 hours.

The exception that proves the rule? Unfortunately not.

The Baby Paige review found there were systematic issues that needed to be addressed including improved access to care, better co-ordination of care, and more effective communications between care providers and between providers and patients and their families. Three years later, the Patient First Review found a wide variety of similar cases with many of the same causes.

> *"For over a year, my husband went back and forth to our family physician who repeatedly prescribed haemorrhoid treatments for his rectal pain and bleeding. At no time was a fecal sample taken. It finally got to the point where he was in so much pain that I went to the doctor with him. ... Finally this doctor called to get my husband into a hospital nearby. Once we got there, we got x-rays right away and serious blockages were discovered. No one really explained to us what this meant. Eventually we went to Regina by ambulance and after a few hours, we were given a diagnosis of rectal cancer. So all that time my husband had been treated for haemorrhoids; he was really suffering from rectal cancer!"*
> *(Patient)*

> *"My youngest daughter, when she was 3 months old, was very ill. I took her to a paediatrician who said she was fine and probably just had a milk allergy but she didn't get any better. I then took her to a walk-in clinic doctor and they told me that she was fine too. Finally I had to take her to the ER because she was getting worse. They had to hook her up to an IV because she was severely dehydrated. They figured out she had a bladder infection that had gone into her blood stream. They told me that she could have died if it had all been left another day. They had to put a catheter in her. None of the doctors before had even taken a simple urine sample. It was a nightmare – it could have been a really fatal error."*
> *(Patient)*

> *"My mother has been abandoned by our health care system. She had a fractured and dislocated shoulder which was improperly looked after. No follow up x-ray was done at emergency to make sure the shoulder was fixed. One year later three surgeries were required to repair it as a result of negligence by the emergency doctor and poor decision making by the surgeon. She ended up having a severe stroke which has left her mentally incompetent. The system has dumped her in my lap!!"*
> *(Patient)*

So what does it take to create a permanent improvement to the system? In our discussion with patients, providers and stakeholders, we identified four underlying conditions for successful transformation:

- **Improved leadership at all levels of health care** – leadership must set the vision, establish the targets, and be vigilant in monitoring the performance of their organizations.
- **Attitudinal/cultural shifts** – changing the attitudes and cultures of health care organizations and staff to think of patients as partners in their own care, and as equal members of the care team.
- **Open communications** – patients want to know who, where, what, when, why, and how the care is being provided. The more patients know (within reason of course), the better they are able to manage their own stress and anxiety levels within the system. Patients, regardless of background or beliefs, must be communicated with in a manner that is appropriate so that they understand their health and next steps.
- **Behavioural shifts** – With the change in attitude/mindset, and more open and culturally appropriate communications, the behaviours of health care staff should shift to be more inclusive with the patient in the provision of care, including them in decision-making, listening to and considering their thoughts and opinions, and treating them as equals.

In the review of other jurisdictions pursuing the goal of a patient-centred system, seven distinct lessons were identified for Saskatchewan. Those seven lessons are consistent with the four from the Patient First consultations and include:

- **Leadership must be fully committed** – in order to shift organizational attitudes and behaviours from current practices to a patient-centred model, the direction must be established from the top, and must permeate through the entire organization. Leadership must be willing to make a long term commitment, and must define what being patient-centred means to their organization. The strategic directions must be reflected in all aspects of the organization including clinical processes, human resource management, education and training programs, corporate communications, as well as performance management.

- **A paradigm shift is required on how patients are viewed** –A shift in thinking needs to happen with organizations and their staff. That shift is going away from the traditional view of the patient as being someone who is visiting a health care professional to be cared for, to a patient-centred view of the patient as an equal partner in the care team. Patients want to feel like they are able to provide input into their own care, that they have options and choices to make, and that they are treated as equal partners ***working with*** a health care team rather then being ***worked on*** by health professionals.

- **The core concepts provided by the Institute for Family-Centred Care encapsulate what it means to be patient-centred** –The Institute's core concepts really resonated with the collective thinking across Canada, US, and the UK on what patient-centred care means. Their four concepts of dignity and respect, information sharing, participation, and collaboration could serve as a set of simple and useful guidelines for any organization looking to become patient-centred.

- **Patient and family participation on committees** –Involving patients and their families is a powerful mechanism for them to provide input into how health care is delivered. In addition to the direct impact on plans and strategies, this seemed to be an effective and meaningful way to instill the values of a patient-centred culture into the organization by showing staff that patient and family input into how health care is delivered is important, and even critical.

- **No system is the same** – there is no "one size fits all" when it comes to health care delivery models, so an organization should be diligent, and start the process of inclusion early in defining the strategy, by taking the time to understand what patients want and expect from them.

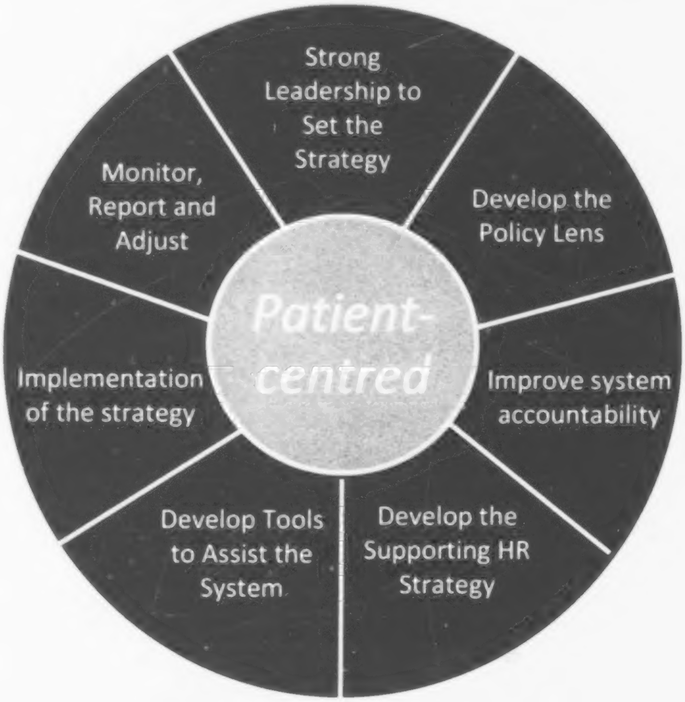
- **Clinical performance benefits can result from being patient-centred** – being patient-centred sounds on the surface to be "touchy feely" and not easily translatable to performance improvement outcomes. The body of evidence is showing that not only are patients' satisfaction ratings going up in patient-centred systems, but organizations are enjoying actual performance benefits (e.g. reduced length of stay).

- **Improvement opportunities are broad and organization-wide** – in order to transform the organization to become patient-centred, changes and improvements are needed in areas that span the entire health care organization. Becoming patient-centred is a journey and it will take each organization many years to make all the necessary changes. This reinforces the point made earlier around leadership making a long term and deliberate commitment to this transformation.

5. Recommendations to Transform the Health System

When we pull together the insights from both the consultations and the jurisdictional review, a clear path emerges for moving forward to a better health care system in Saskatchewan.

Moving to a Patient-centred Health System


Strong Leadership to Set the Strategy
Develop the Policy Lens
Improve system accountability
Develop the Supporting HR Strategy
Develop Tools to Assist the System
Implementation of the strategy
Monitor, Report and Adjust
Patient-centred

The model illustrated above provides a quick overview of the first set of recommendations made to the Commissioner within the detailed report on how the Province of Saskatchewan could approach a system-wide shift to becoming a patient-centred system. This set of recommendations is presented at a high level below, and has been elaborated upon in the detailed report:

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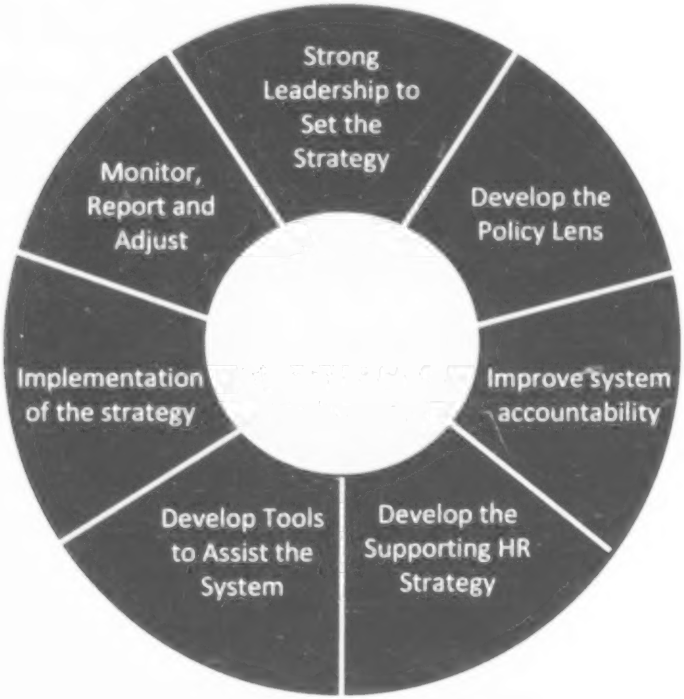
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1. **Establish strong leadership to set the strategy:** The strategy starts with a commitment from the top. The defining aspect of that commitment is courage. While we believe Saskatchewan currently enjoys a very positive environment to implement change for the better, no matter how collaborative the process, not all stakeholders will support every decision and most decisions will be implemented imperfectly. When mistakes are made or circumstances are more difficult, it will take courage for leaders to stick to the strategy instead of reacting to the crisis of the moment.

2. **Develop a patient-centred policy lens:** The policy lens is fundamental to a long term transformation. The policy lens is a tool that assesses system initiatives from a patient perspective. It asks questions such as, how does the proposed initiative improve the patient experience and how has patient input and feedback been solicited and considered?

3. **Improve system accountability:** The need to improve system accountability was a core finding of all three elements of the consultation process. The input from participants and suggestions for implementation are covered in detail in the report. The key point to make in this summary is "You get what you measure". Since we don't measure the human costs and benefits, we don't incent behaviours that enhance caring and compassion within the patient journey and may, in some cases, unintentionally discourage the behaviour we seek.

4. **Develop the supporting human resources strategy:** Developing the supporting human resources (HR) strategy is a fundamental enabler of a patient-centred system. Saskatchewan has already embarked on the development of a 10 year health human resource strategy. It will be critical to ensure the strategy is aligned with a patient-centred system and not in conflict with it. It is also important to remember that while top-level commitment to a patient-centred system is necessary, it is not sufficient. Patient-centred care is delivered at the front line. With that in mind, it is important that early milestones be developed to demonstrate progress to health providers as well as patients.

5. **Develop tools to assist the system with transformation:** Developing tools is a mechanical but necessary task. Some of these tools – particularly enhancing the Province's existing system of electronic health records – are huge tasks that will take time. Other tools, such as developing provincial resources to assist front-line organizations in process improvement, can be implemented much more quickly and will leverage the advancement of others.

6. **Implementation of the system transformation:** Implementation comes back to the question of where the institutional responsibility will lie. Health system leaders are busy people with many operational and strategic demands on their time. Based on our understanding of successful and less successful Canadian attempts at fundamental health care change, we have recommended that a specific, dedicated Patient First Transformation Team be established to advocate for change and be accountable for the results. The government could establish the team as a program in the Ministry, a program in the Health Quality Council, as a stand alone agency or through another vehicle, just so long as the Patient First initiative has a champion.

7. **Monitor, report and adjust:** Finally, the key point of the "monitor, report and adjust" recommendation is that moving to a patient-centred system is a journey. While we strongly recommend the system leadership develop a continuous set of milestones to focus efforts and provide demonstrations of success, the reality is that fundamental cultural and institutional change requires long lead times during which circumstances change, lessons are learned and adjustment is required.

6. The First Steps

In section 3 we set out the patients' vision for a better health care system. In section 4, we discussed how we move to a better health care system. In this section, we turn to the first steps required to make this vision a reality.

There is no shortage of ideas for how to improve the Saskatchewan health care system. During phases one and two, the patient and provider random discussion groups and work books brought out over 150 ideas on how to improve the health care system. By the end of the stakeholder discussion groups, we had over 450 ideas for improving the health care system. One surprise was the striking level of consensus between patients and providers. Almost all the provider workbooks and discussion participants fully embraced the summary of patient experiences. It some respects this shouldn't have been a surprise given we are all patients whether we work in the health system or not. However, the Patient First Province-wide telephone survey adds further insight as we learned that health care workers are almost twice as likely to be providing voluntary care to a friend or family member as the average. Providers are experiencing the system as patients and fully identify with patient concerns.

All of these ideas have been documented and will be available for health leaders to mine as they develop their own transformation strategies. However, to help establish an overall agenda of change for the better, the responses were coded into an initial set of 19 categories of improvement, with the final set of 6 categories noted below. Full details of this categorization process and results can be found within the detailed report.

This second round of distilling was done to better organize the suggestions to develop a manageable, focused agenda for change for the better. Not surprisingly, the final six categories for improvement are very similar to the five characteristics of a patient-centred health care system as identified in the analysis of positive and negative experiences. Below we summarize the key categories for improvement.

Categories of Improvement

1. **Improving the quality of patient interaction:** This category includes solution areas focused on strengthening patient relationships and communications.
    - Strengthening patient relationship
    - Improving Communication between the System and the Patient

2. **Improving the quality of patient interaction:** This category includes solution areas focused on strengthening patient relationships and communications.
    - Strengthening patient relationship

3. **Improving Communication between the System and the Patient**

4. **Improving system integration**: This category includes solutions aimed at improving coordination of care and health information management.
    - Improving Health Information Management
    - Improving Coordination of Care

5. **Improving access to quality, safer health care**: This category includes issues of improving flow through emergency care, improving throughput of surgeries & diagnostics and reducing the backlog, accelerating and expanding access to mental health care and support, child and maternal care and support, and access for residents in remote and rural locations.
    - Enabling all health care providers to work to their full scope of practice
    - Improving access to hospital care in emergencies and urgent cases
    - Improving Wait times for Surgeries and Diagnostic Tests
    - Improving Home Care Effectiveness
    - Improving Geriatric and Long-term Care Support
    - Improved access for people living in rural and remote parts of the Province
    - Improving Child and Maternal Health Care Support
    - Improving Mental Health Care Support

6. **Improving system accountability:**
    - Improving Performance Management

7. ***Building a stronger health care work force:*** Improving retention and recruitment, staff morale and sensitivity-training
    - Improving health care leadership system-wide
    - Implementing effective strategies to build and develop the workforce
    - Boosting staff morale
    - Improving cultural sensitivity/competency of health care workers

8. **Improving health protection and promotion activity in the Province**: Implementing system-level, community-level and individual-level strategies to promote wellness and prevent illness
    - Improving communication on the role that patients must play in improving and maintaining their health
    - Increase quality of, and access to, health promotion activities and interventions

These categories of improvement have a distinct meaning to the government and health care providers. They will review these categories, and determine what system and/or clinical improvement projects can be implemented in order to address the issues within each category. A summary of KPMG's recommendations to address each category is provided later in this section. But this is the Patient First review, and so the journey to become a patient-centred system must start by ensuring that our analysis of how to improve the system is in the patient's voice, and is easily understandable to patients. "Provider talk" is necessary for the system to implement change; however now we must start thinking like patients in order to plan system change with their needs and voices in mind. The table below expresses these categories of improvement in the voice of patients and how they have asked for the system to make changes and improvements.

Heard through the patient's voice, these categories for improvement were then used to create a patient-centred prism to provide recommendations to the Commissioner for the government and the health care system on how to implement the improvements needed to address the issues and requests from the patients. These recommendations have been organized by category of improvement and are communicated in system/provider terms of reference so that they are understood by the intended audience, but are always framed in the context of the patient voice. The table below also reflects each of the recommendations made by KPMG to address and improve the issues heard from the patients.

Category of Improvement	Improvements Requested in the Patients' Voice	KPMG Recommendations
• Improving the quality of patient interaction	• Change the way my physician interacts with me, allowing me more time to explain all my concerns and allowing him/her time to explain my full range of options for care. • Provide me with someone I can talk to who is familiar with my care and who can help guide me through the system. • Provide me with information at every stage of my care journey, especially on how long I have to wait and why I have to wait. • Improve your communication with me throughout my care journey, especially letting me know who each provider is and their assigned role.	• Provide incentives / remove disincentives for providers to have longer visit times and engage patients in a discussion about their care options. • Move towards more inter-disciplinary team-based care that leverages physician resources and increases the time available for patients. • Increase access to Case Management / Patient Advocates. • Communicate estimated wait times in Emergency and for surgery shortly after a surgical decision is made, and support patients through their wait. • Provide mandatory staff identification badges that clearly identify who they are and their position in the organization.
• Improving system integration	• Give my doctor tools to communicate more effectively with my specialists and other healthcare providers so I no longer have to repeat my self continuously and my information is not lost between them.	• Build on current information technology infrastructure to expand the use of an Electronic Health Record (EHR). • Expand access to inter-professional care teams. • Develop cross-continuum programs

Category of Improvement	Improvements Requested in the Patients' Voice	KPMG Recommendations
	• As a patient with chronic diseases, improve the way my providers work together to help me reach my health goals. • Improve the coordination of care between my hospital stay and home care.	focused on specific patient populations (e.g. patients with Diabetes) with shared accountability for patient outcomes. • Standardize discharge planning processes.
• Improving access to quality, safer health care	• Reduce the amount of time I have to wait for emergency care. • Reduce the amount of time I have to wait for surgical procedures and diagnostic tests. • Improve/expand the options for care and the ease with which I or my family/caregivers can access geriatric and long term care services in my community. • Make it easier for me to access care when I live in a rural or remote area. • Make it easier for the First Nations and Métis residents to access care, and make it appropriate and sensitive to the needs of my community. • Improve/expand the options for care and the ease with which I or my family/caregivers can access mental health and addictions services.	• Optimize flow of emergency care from a systematic perspective, focusing on the bottlenecks in patient flow concerning the emergency from end to end. • Optimize flow in surgical and diagnostic care from a systematic perspective, focusing on the bottlenecks in patient flow from end to end. Wait times and surgical/diagnostic backlogs are a huge burden to the system. • Develop cross-continuum programs for seniors with complex needs. • Develop a rural care strategy. • Develop a First Nations and Métis health care strategy. • Assess demand for services and develop a strategy to create adequate capacity to meet population need.
• Improving system accountability	• Teach providers how to meet my needs. • Improve the supervision of staff in the emergency department and hospital wards to prevent rude and inappropriate behaviour. • Pay care providers based on whether my needs are met. • Let me know how my providers	• Implement a Province wide framework to shift the culture of providers towards providing patient-focused care. • Expand nurse manager capacity for improved ward management. • Change performance appraisal systems that reward and recognize patient-centered behaviours, and

Category of Improvement	Improvements Requested in the Patients' Voice	KPMG Recommendations
	are performing. • Give me someone I can talk to when I have a complaint.	alignment with patient-centered values. • Make public reporting on performance mandatory including measures on access, and patient satisfaction in a way that is easily understood by the general public. • Implement a health Ombudsman to field and resolve patient complaints, building on the current model of client representatives and quality of care coordinators already in place.
• Building a stronger health care work force	• Clarify and make full use of every provider's abilities so that I have better access to care and so that providers are better utilized. • Help us to develop more First Nations / Métis heath professionals in the workforce. • Improve working conditions so that my doctor isn't changing every two years.	• Clearly define and make use of providers' full scope of practice. • Develop an advanced practice program. • Develop a First Nation/Métis recruitment strategy. • Provide retention incentives for health care workers to remain in the Province. • Expand nurse manager capacity for improved ward management.
• Improving health protection and promotion activity in the Province	• Provide me with the knowledge and tools I need to help me stay healthy. • Health education is an important part of my community and should be delivered in my community.	▶ Improve public education on chronic disease management and prevention. ▶ Develop strategies to empower patients for self-care. ▶ Involve schools in the promotion of health in communities. ▶ Increase physical activities in schools,

Each recommendation made to the Commissioner is expanded upon within the detailed report. These recommendations were assessed both in terms of the effort required and the potential impact. Recommendations were then further screened to help the system identify both *short term wins* and *longer term priorities*. Within the detailed report, a set of supplementary recommendations were made that represent additional initiatives that could be implemented as supports to the recommendations detailed above.

For details on these supplementary recommendations, please see the detailed report at www.health.gov.sk.ca/patient-first-review.

"Short term" is considered achievable within the first year. The short term initiatives listed in the table below are those that are more easily implemented and with the least amount of effort. The Province should be able to quickly show progress in addressing the patient issues identified. Some of these initiatives include finding ways to communicate more effectively with patients that include providing them with information on their wait time and ensuring they have access to the care they need while they wait. Another early initiative is involving patients in the redesign of care processes. This can be easily achieved and can demonstrate quick results.

"Medium term" is considered achievable within the first three years. The medium term initiatives identified in the table below require more analysis, system change or take more effort to achieve. Examples of medium term initiatives include changing performance appraisal systems to reflect and reward for patient centered behaviours. Another important initiative that will have high impact that can be achieved in the short-to-medium term is the enhancement of nurse manager capacity within the system to provide the important supervisory role and to mentor and provide staff guidance on appropriate patient-centered behaviours. Other initiatives with high impact and medium term achievability include the expansion of Electronic Health Records, and the optimization of Emergency, surgical care and diagnostics.

"Long-term" initiatives will take up to five years. The long term initiatives will take a much longer time to implement and will likely require structure and infrastructure to support their ongoing implementation. These initiatives will also take longer to demonstrate value. One of the initiatives that will have high impact as noted in the table below includes the cultural transformation of the health care system.

The table on the next page outlines the recommended initiatives by both category of improvement and timing. Those recommendations marked with an asterisk (*) are recommendations provided by KPMG that are supportive of and in addition to those provided in the table above. Combined these initiatives will demonstrate immediate action and results while continuing the ongoing transformation of the Saskatchewan health care system.

Recommended Initiatives By Time and Category of Improvement

Short Term (One Year)

- Communicate estimated wait times and support during the wait
- Provide mandatory staff identification badges
- Celebrate patient-centred performance with recognition & awards*
- Standardize discharge planning integrated into the community
- Implement a patient ombudsman
- Involve the patient in the redesign of care processes*
- Develop First Nations/Métis recruitment strategy
- Expand recruitment and retention incentives
- Develop a diversity and sensitivity training program*
- **Improve public education on chronic disease management and prevention**
- **Increase physical activity in schools**

Medium Term (3 Years)

- Provide incentives / remove disincentives to encourage longer visits
- Measure patient-centered behaviours & modify performance appraisal systems
- Provide incentives and reward team-based care*
- Build on current IT infrastructure to expand the use of EHR
- Develop Chronic Care Strategy*
- Expand nurse manager capacity
- Optimize Flow in the Emergency
- Optimize Surgical and Diagnostic Care and increase capacity
- Develop Rural Care Strategy
- Develop First Nations and Métis health strategy
- Survey Patients and institute formal mechanisms to improve processes*
- Develop Management training program*
- Increase clinical supervision*
- Develop cultural safety perspective*
- **Develop strategies to empower Patients for self-care**
- **Involve schools and communities in health promotion**
- **Develop health promotion strategy with public reporting on indicators***

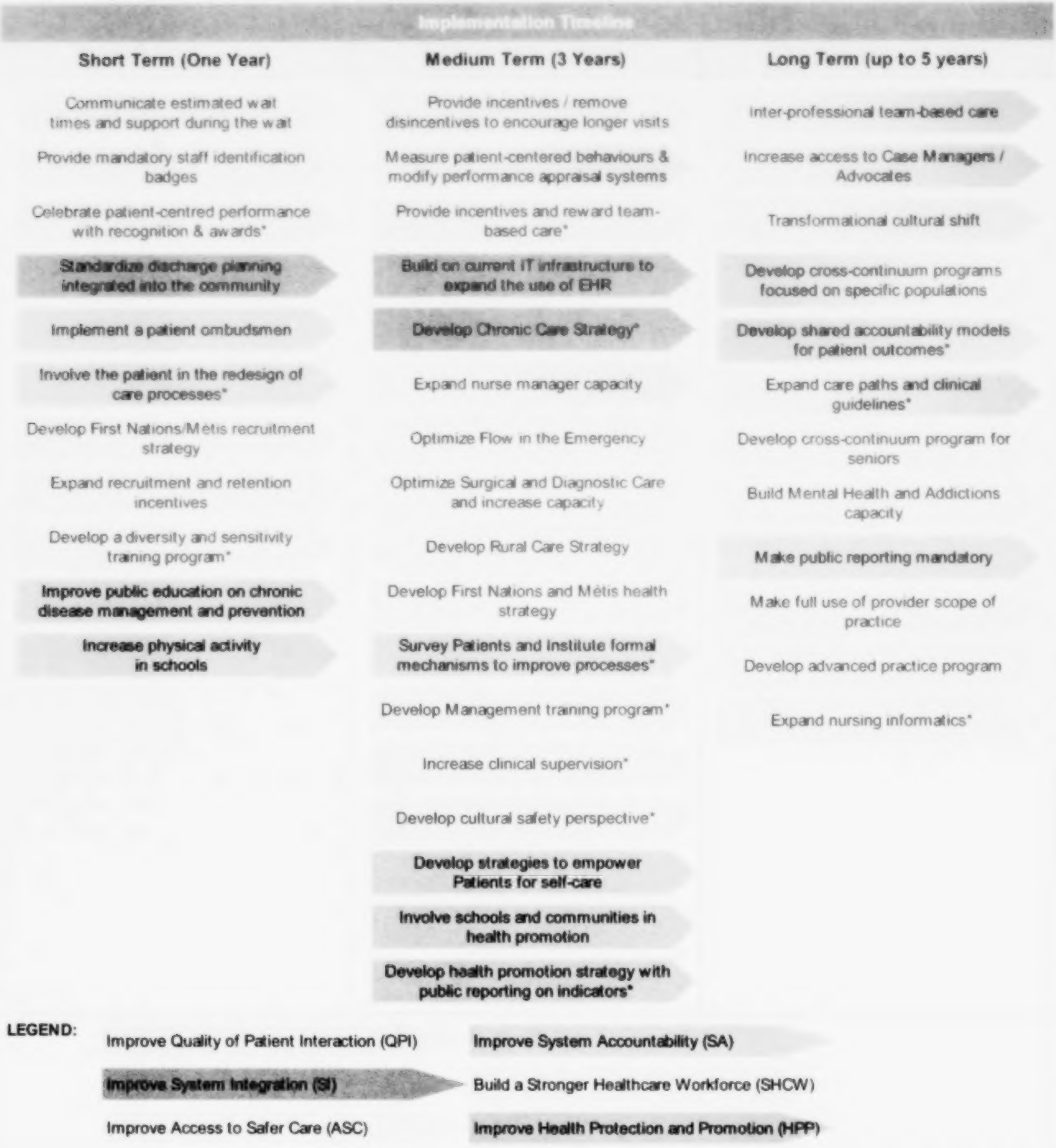
Long Term (up to 5 years)

- Inter-professional team-based care
- Increase access to Case Managers / Advocates
- Transformational cultural shift
- Develop cross-continuum programs focused on specific populations
- Develop shared accountability models for patient outcomes*
- Expand care paths and clinical guidelines*
- Develop cross-continuum program for seniors
- Build Mental Health and Addictions capacity
- Make public reporting mandatory
- Make full use of provider scope of practice
- Develop advanced practice program
- Expand nursing informatics*

LEGEND:

Improve Quality of Patient Interaction (QPI)
Improve System Accountability (SA)
Improve System Integration (SI)
Build a Stronger Healthcare Workforce (SHCW)
Improve Access to Safer Care (ASC)
Improve Health Protection and Promotion (HPP)

Recommended Initiatives By Time and Category of Improvement



Implementation Timeline

Short Term (One Year)

- Communicate estimated wait times and support during the wait
- Provide mandatory staff identification badges
- Celebrate patient-centred performance with recognition & awards*
- **Standardize discharge planning integrated into the community**
- Implement a patient ombudsmen
- **Involve the patient in the redesign of care processes***
- Develop First Nations/Métis recruitment strategy
- Expand recruitment and retention incentives
- Develop a diversity and sensitivity training program*
- **Improve public education on chronic disease management and prevention**
- **Increase physical activity in schools**

Medium Term (3 Years)

- Provide incentives / remove disincentives to encourage longer visits
- Measure patient-centered behaviours & modify performance appraisal systems
- Provide incentives and reward team-based care*
- **Build on current IT infrastructure to expand the use of EHR**
- **Develop Chronic Care Strategy***
- Expand nurse manager capacity
- Optimize Flow in the Emergency
- Optimize Surgical and Diagnostic Care and increase capacity
- Develop Rural Care Strategy
- Develop First Nations and Métis health strategy
- **Survey Patients and institute formal mechanisms to improve processes***
- Develop Management training program*
- Increase clinical supervision*
- Develop cultural safety perspective*
- **Develop strategies to empower Patients for self-care**
- **Involve schools and communities in health promotion**
- **Develop health promotion strategy with public reporting on indicators***

Long Term (up to 5 years)

- Inter-professional team-based care
- Increase access to Case Managers / Advocates
- Transformational cultural shift
- Develop cross-continuum programs focused on specific populations
- **Develop shared accountability models for patient outcomes***
- Expand care paths and clinical guidelines*
- Develop cross-continuum program for seniors
- Build Mental Health and Addictions capacity
- **Make public reporting mandatory**
- Make full use of provider scope of practice
- Develop advanced practice program
- Expand nursing informatics*

LEGEND:

- Improve Quality of Patient Interaction (QPI)
- **Improve System Accountability (SA)**
- **Improve System Integration (SI)**
- Build a Stronger Healthcare Workforce (SHCW)
- Improve Access to Safer Care (ASC)
- **Improve Health Protection and Promotion (HPP)**

7. Looking Ahead

The Patient First Review is one of a series of initiatives that have been launched by the Saskatchewan Ministry of Health to move the Province's health care system from being provider-centered to becoming patient-centered.

The Ministry and its partners have already embraced the concept of patient-centered care. The need for some improvement is self evident to anyone who has been a patient in the system, and everyone is a patient from time to time, even those who run it. This year's strategic planning process focused squarely on the challenge of doing a better job of meeting patient needs.

However, the Ministry also recognises that those who run the system are often too close to the nuts and bolts to truly see the system as it is experienced. That's where the Patient First Review came into play, giving voice to Patients who have few other inputs into the system as it exists today.

8. Telephone Survey Overview

The final phase of the Patient Experience component of the Patient First Review consisted of a Province-wide telephone survey among Saskatchewan residents. The survey was designed to provide patients with the final word in the review, with questions structured in such a way as to provide quantifiable benchmarks and further check the patient "experience". 1,076 residents had participated in the survey. The respondents consisted of a regionally representative sample of Saskatchewan residents from across the Province: 24% from the North, 19% from Regina, 22% from Saskatoon, 22% from the South and 13% from Central Saskatchewan. The participants were all 18 years of age and older, with a 48%/52% split between male and female respondents. The survey also successfully achieved its quota for First Nations and Métis respondents that are representative of the Province as a whole, representing 8% (82) and 7% (75) of sample respectively.

The detailed results of the survey are provided as an Appendix to the detailed report. Some of the highlights of the survey are provided below. In general, the survey showed that the Province is heading in the right direction but still has a great deal of room for improvement.

The survey benchmarks patient views at three different levels:

Perceptions of the system as a whole.
Evaluations of the overall level of care personally received.
Evaluations of specific patient journeys.

The evaluation of patient journeys is the most distinct aspect of the Patient First Province-wide telephone survey.

The survey also differentiated groups of people who may view the system differently. The survey used three types of segmentations for this purpose: basic demographics including age, gender, First Nations or Métis ancestry and lifecycle status; health characteristics including chronic illness, being a health employee and being a care giver; and general health attitudes. Of the health attitudes, two stood out as particularly critical; consumerism and navigation confidence.

Attitudes turned out to be the most important segmentation variable. Among attitudes, confidence in system navigation is the single most consistently powerful predictor of differences in patient experiences. Almost half of residents - 47% - agree with the statement that "The health care system is so complex that I worry that if I become ill I will not be able to find the help I need." Patients who agree with this statement are much more likely to provide negative ratings of the health care system than those who disagree. In some cases, people concerned about their ability to navigate the system gave negative ratings that were twice as high as those who were confident.

Consumerism as measured by a respondent's interest in doing their own research is also correlated with lower scores. On average those with higher levels of consumerism are about 8 points less satisfied than those who are more deferential. However, the strongest correlation to high system ratings appears to come from confidence in being able to navigate the system. People who are confident they can find the help they need are twice as likely to give the system a positive rating as those who are not confident.

Perceptions of the System as a Whole

Perceptions of the system as a whole are collected both through ratings and belief statements. Three ratings were used:

- "How would you describe the overall quality of health care available in your community today?"
- "In general, would you say that the health care that patients receive in Saskatchewan is better or worse than the health care that patients receive in the rest of Canada?"
- "In general, would you say that the health care that patients receive in Saskatchewan is better or worse than the health care that patients receive in the United States? "

In addition, two agree/disagree belief statements explored overall systems assessments:

- The Saskatchewan health care system puts patients first.
- In general, health care workers in my community care about patients and treat them with respect

The system gets moderate grades for overall quality. Just 12% say the system gives 'excellent' care but even fewer (5%) say it gives 'very poor' care. The common responses were 'good' (38%) and 'acceptable' (31%). In other words, most days the system delivers at least adequate care, but there is room for improvement.

Saskatchewan residents see their system as similar to other systems in Canada but as much better than the American system. One third (34%) say the health care received by patients in Saskatchewan is the same as elsewhere in Canada, 19% say better and just 12% say worse. However a clear majority of 56% say patients in Saskatchewan receive better care than those in the US.

Almost three out of four people in Saskatchewan feel their health care system puts people first (73%) but just 19% strongly agree with that view point suggesting the system is headed in the right direction but still has a way to go before it reaches its destination.

Nine-in-ten (89%) agree that health care workers in their community generally treat patients with respect. With almost half (48%) in strong agreement, this is an area where the system is generally performing well. However, with 41% only somewhat in agreement, there is room to improve even here.

Evaluations of the Overall Level of Care Personally Received

Perceptions of the system as a whole are collected both through ratings and belief statements. Two ratings were used:

- Generally speaking, how would you describe the quality of the health care services provided to you and your family in the last 12 months?
- Generally speaking, how would you describe your ability to access health care services for yourself and your family in the last 12 months?

In addition, four belief statements covered topics related to personal experience:

- I am confident that if I had a medical problem I would receive the treatment I needed in Saskatchewan as soon as I needed it.
- I feel that I have a say in decision-making about my health care.
- My personal health care information seems to get lost in the health care system.
- I have experienced unacceptable conduct from health care workers such as rude or dismissive behaviour.

The grades go up when people report on their overall personal experience over the past 12 months compared to assessing the system in general. Generally speaking, the baseline measures for patient assessments of the overall system are 12% of patients feeling it is 'excellent', while 38% feel it is 'good'. When assessing their overall personal experience over the past 12 months, the number saying 'excellent' grows to 19% while 'good' increases to 42%, resulting in an eleven point gain in total good or excellent mentions. Saskatchewan patients feel their own experience is better than average.

Personal access receives almost exactly the same score as overall personal experience, suggesting access is a likely key driver of overall experience.

People under 45 without children are much more favourable on all of these ratings than those with children or those over 45. The groups with the lower ratings are more likely to need the system than those with high scores.

Evaluations of Specific Patient Journeys

Patient journeys were explored through mini-surveys. The mini-surveys included two types of questions:

- **Descriptive** - When did this experience happen and which service silos did you touch?
- **Evaluative** – How would describe your overall experience and your experience on six specific attributes.

In terms of the descriptive results, it is impressive how many of the journeys occurred very recently highlighting the pervasiveness of direct experience with the health care system.

Forty percent of these experiences occurred with the past three months. Seventy percent were within the last year.

The critical role of primary care is re-enforced by the fact that over 80% of these journeys include primary care with the next highest silo experience (diagnostics) trailing a distant second at 53%.

Ratings for the latest experience in the mini-surveys were considerably better than the average rating for the year. Generally speaking, when asked to speak to the overall quality of services provided in the last 12 months, respondents rating their care as 'excellent' or 'good' were 19% and 42% respectively. As it relates the their latest experiences with the health care system, almost 3-in-10 report excellent care and another 35% said 'good'. Just 5% said 'very poor' while 10% said 'poor'. Still room for improvement, but there is much more passionate approval for individual care experiences than for care on average across the year. The most problematic areas included care for an aging friend or family member and care for a mental or emotional health condition. By far the best ratings were for maternal or reproductive care.

Waiting times were the greatest cause for concern in these patient journeys. Just under 3-in-10 patient journeys generated a poor or very poor rating for the length of waiting times. Specialists wait times are the most common wait time issue but wait times for ER are number one for children and elderly care. Primary care and diagnostic waits are also common. Only maternal or reproductive health journeys beat the negative trend.

The other major cause for concern was transitions from one part of the system to another with 20% providing a 'poor' or 'very poor' rating. At 12% 'poor' or 'very poor', the third highest problem (communications of next steps) was directly tied to the transition issue. Transition problems occur primarily when moving from primary care to a specialist or diagnostics. Issues around communication of next steps occur pretty much evenly across primary care, surgery and specialists. Again, maternal or reproductive health journeys fared best on these measures.

Knowledge of staff was a particular problem in mental or emotional health journeys and care for a child with a serious illness. While relatively rare, problems with courtesy and listening skills were experienced very evenly across the system.

Most of the open-ended comments for improvements focus on wait time reductions as a goal or on specific initiatives (hire more staff, increase bed space) to increase capacity in order to reduce wait times. Most of the remaining comments center on improving patient-provider interactions with more time or better communications. Improved communications is particularly important in the case of child and elderly care and, to a somewhat lesser degree, mental or emotional health.

Highlights of First Nations and Métis Results

The Patient First Review included of a number of measures to encourage First Nation and Métis participation such as:

- Dedicated qualitative input sessions for First Nations and Métis participants;
- Quotas to ensure First Nations and Métis were represented in general public qualitative input sessions;
- Invitations to First Nations and Métis providers and stakeholder groups to participate in the provider and stakeholder sessions; and,
- Quotas to ensure First Nations and Métis respondents were appropriately represented in the Patient First Province-wide telephone survey.

Consistent with the findings from the discussion groups, the Patient First Province-wide telephone survey found that First Nations, Métis and residents of rural regions generally report lower satisfaction ratings than other groups. The qualitative input suggests this is the result of two particular challenges. The first is that many First Nations and Métis respondents came from rural and remote communities and shared the access and cost issues experienced by other rural and remote residents. The second problem was a lack of cultural sensitivity and support that was experienced by First Nations and Métis respondents from both rural and urban settings.

Consistent with that qualitative finding, the biggest area of concern from the Patient First Province-wide telephone survey is the finding that 45% of First Nations and Métis participants have experienced unacceptable behaviour compared with 30% among people with other backgrounds.

Looking at the Patient Journey results, First Nations and Métis respondents are fairly typical in their need for acute care. However, First Nations and Métis respondents are more likely to experience every other health condition we measured. The table below provides a summary of the health incidences amongst those First Nation and Métis survey respondents.

Numbers indicate the percentage from each life cycle group to report having had the following system experiences	First Nations	Metis	Neither
Serious Medical Incident	30%	22%	24%
Care for an aging family member	31%	22%	23%
Long-term medical condition that has reduced the amount or kind of physical activity you can do	24%	28%	21%
Chronic illnesses	30%	35%	25%
Mental or emotional health condition	32%	23%	12%
To have a baby or family planning	25%	26%	16%
Care for a dependent child with a serious illness	17%	14%	7%
Addiction	12%	7%	3%

First Nations and Métis respondents' ratings of their patient journey experience are similar to residents with other backgrounds. This is despite the fact they were more likely to experience Emergency Care which is often a driver of poor assessments.

Their satisfaction on the six service attributes was also similar to people from other backgrounds. One exception was somewhat lower than average First Nations satisfaction ratings for listening skills and courteousness, but the differences were relatively small and Métis respondents did not share this concern. This suggests that the high level of experience among First Nations and Métis people with unacceptable behaviour may be more from older experiences than more recent experiences, but more tracking is needed to be confident that there is an improving trend.

9. Research Tracking Recommendations

Historically patient satisfaction surveys conducted within the Province have produced generally positive results and have shown high levels of patient satisfaction with the delivery of care in Saskatchewan. What the Patient First Province-wide telephone survey has demonstrated is while many residents and patients are generally satisfied with the level of care they receive in the Province, there is still a clear demand for improvement.

A summary of the minimum set of measures we recommend be tracked on an ongoing basis and the baseline results from the Patient First Review are provided in the table below:

Summary of Recommended Minimum Set of Measures for Ongoing Tracking

Measure:	*Baseline result:*
• Patients like to do their own research before they take their doctor's advice	• 56% agree
• Patients expect to be major decision-makers in their own care.	• 56% agree
• Patients feel that the health care system is so complex that they worry that if they become ill they will not be able to find the help they need	• 47% agree
• Patient assessment of the overall quality of health care available in their communities today	• 38% describe the care as 'good' while 31% describe it as 'acceptable'
• Saskatchewan residents' view of their health care system compared to other systems in Canada and in America	• 34% say the health care received by patients in Saskatchewan is the same as elsewhere in Canada, 19% say better and just 12% say worse. • 56% say patients in Saskatchewan receive better care than those in the US.
• Patients feel that the Saskatchewan health care system puts people first	• 73% agree, only 19% strongly agree
• Patients who have experienced unacceptable behaviour from health care workers	• 30% have had this experience • 45% of First Nations and Métis have had this experience

Measure:	*Baseline result:*
• Patients believe that health care workers in their community generally treat patients with respect	• 48% strongly agree • 41% somewhat agree
• Patients grading their personal experience over the past 12 months compared to assessing the system in general.	• 19% said their experience was 'excellent' • 42% described their experience as 'good'
• Track specific patient journeys from the patients' perspective by initially asking about conditions rather than service silos.	• Various results depending on journey, see detailed results
• Patients' view of how acceptable the length of wait times are in their journey	• 29% said they were poor or very poor
• Patients' view of how good their transitions are from one part of the system to another during their patient journey	• 20% describe their transitions as poor or very poor. • 53% of problem transitions begin in primary care
• Patient view of how effective/good system communications of next steps in the system are during their specific journeys.	• 12% describe communications as 'poor' or 'very poor'

By initiating and successfully completing the Patient First Review, the Province is making a commitment to patients to look for ways to improve the delivery of care, to make it more patient-centred, and to remain focused on tracking and monitoring patient satisfaction. The recommendations we have made for system transformation and for improvements to the way health care is delivered within the Province will require a long term commitment from the Province and its health care constituents. The recommendations outlined within this section outline how the Province should approach the collection of ongoing patient feedback in order to track and monitor results against the desired goals of becoming more patient-centred and improving patient satisfaction.

1. ***Continue to undertake patient satisfaction surveys.*** We recommend that the Province continue to undertake Patient First surveys such as the one initiated for this review.

2. ***Initiate both broad and focused surveys.*** System-wide surveys such as that undertaken for this review can provide the Province with information spanning the entire system and touching on multiple issues/pain points within the system. We recommend that the Province continue with these system-wide surveys, but also consider initiating mini-surveys that focus on one or more specific issues (e.g. wait times, provider behaviour, etc.). The Province could also follow each process or system improvement project with a survey in order to gather information on the performance improvements that may or may not have been realized from the implementation of different initiatives.

3. ***Continue to survey on several critical items that emerged from the Province-wide telephone survey.*** The detailed survey questions and results provide the Province with a wealth of information to guide and plan system improvements. We strongly recommend that the Ministry and its delivery partners include the following elements in future surveys:

    - **System navigation.** This item had by far the strongest relationship with patient satisfaction.

    - **First Nation and Métis patient experience with negative provider behaviours.** It is important to track both First Nations and Métis ancestry and experiences with unacceptable provider behaviour on an ongoing basis given the high levels of reported historic unacceptable provider behaviour.

4. ***Build on the patient journey approach.*** We would encourage future research to continue to involve individual patient journeys. Not surprisingly, each journey is defined by unique problems and challenges. Solutions that deliver a more patient-centered system need to reflect the unique nature of each journey. It is critical to understand that the patient journey is based on experiencing a condition or symptom. Most patient journeys involve several service silos; as a result a silo based approach fails to capture the whole journey.

    The most important items to test on the patient journey are access and navigation/co-ordination. Communications variables are clearly important, but the relatively high scores on these measures support giving the priority to other areas experiencing more difficulty. The Patient First Review was a first attempt at understanding these journeys. We recommend that the Province continue to analyze and refine these measures and develop additional measures as needed to deal with emergent issues from a patient perspective.

- The first area we recommend as a focus for the development of new measures is the initial diagnoses. As we noted earlier, the Baby Paige experience was not unique. Many of the most powerful patient stories were those relating to delays and failures in diagnoses. Questions related to timeliness and effectiveness of diagnoses would provide an important benchmark to assess how big a problem exists in this area and whether the problems are focused on particular conditions or within particular groups of patients.
- The first priority for refinement is the initial list of patient experiences. Can these items be expressed more simply to make them more accessible to less knowledgeable patients? Are there other important categories that should be added?
- While this survey has served primarily as a descriptive and benchmarking function, it is important that ongoing research be conducted on individual patient journeys to identify key drivers of satisfaction on each journey to ensure that priority is given to the Patient First initiatives that will leverage the greatest improvement in the patient experience. One key to success in the research is to develop larger sub-samples for specific patient journeys.

10. System Recommendations

Similar to reviews, commissions and enquiries that have come before, this Review has developed a wish list of policies and initiatives it believes is necessary. Unlike previous reviews, these are not just the informed views of the Review team. They have been generated by a bottom-up dialogue that began and ended with patients, but also included providers and stakeholders as an integral part of the process.

Many of these ideas have been central and continue to remain central to most health agendas in Canada – waiting list reduction, electronic health records, primary care reform and expanded scope of care to name a few. But some of our recommended ideas have emerged through the unique nature of this review which has challenged us to challenge health care system norms.

First, the most important message from this Review is that the critical success factor in transforming the traditional delivery-based and professionally-based silos of the current health care system to a patient-centred health care system is focusing on process, not just policy. This Review was needed because patients are isolated from their own health care system's planning and governance processes. In fact, patients often feel alienated from the decisions related to their own care. If the process is not changed to give the patient voice an ongoing role, it is inevitable that inertia takes over and the status quo will triumph.

Second, a key benefit of bringing patients into the governance of the system is that we will measure success not just in terms of dollars and clinical outcomes, but in terms of patience experience, both in terms of positive feelings such as peace of mind and comfort as well as negative feelings such as fear, anger and uncertainty.

Third, taking the patient perspective has highlighted the importance of issues of navigation and coordination. While these are often minor items on change agendas generated by system insiders, they are critical drivers of confidence and satisfaction within the patient experience.

Fourth, the core value of a patient-centred transformation is collaboration. Change must be driven from the top, but it is delivered by all levels of the system. A core philosophy of being patient-centred is the engagement of the whole team in a clinical pathway. It is this type of systems-thinking along with process improvement approaches such as Lean that will be critical to achieving the cultural shift that patients are seeking.

Fifth, collaboration includes patients, not only at the planning and governance level but particularly in terms of their own care. The Institute for Family-Centre Care's guidelines do a good job of summarising the conclusions of a wide variety of organizations that have been active in attempting this transformation. As we noted earlier, the patient-centred transformation will not be complete until patients move from being people providers work on, to becoming people providers work with. This is a step beyond the traditional consumer model of customer service to a real working partnership.

Sixth, we have to recognize the system's incentives have often not been designed with the patients' interest in mind. That means that not only are we failing to incent the behaviour we seek, we may well be encouraging the exact behaviours we want to end.

Seventh, while many of the values that are important to the patient experience are intangible, it is critical that we identify measures in order to assess progress. You get what you measure. We recommend the lead agency for the Patient First Review conduct an annual tracking survey based on patient journeys, rather than system silos utilising a consistent set of measures to allow for tracking measures over time.

Eighth, while participants generated a number of ideas that can be implemented at little or no additional costs, there is clearly a need for additional funding to invest in new initiatives to improve the patient experience. Before we ask government for new money, we need to start by reviewing the money already allocated to health care and ask if there is not more than can be done.

Ninth, change will fail without leadership from the top. But how can we call for both a collaborative model AND top-down leadership? By setting clear expectations for leadership. The health system's leadership needs to do three things to create success:

- They need to support and defend the agenda for change which has been driven by patients and their experience. It's the patients' system. It's their right to set the agenda.
- They need to drive decisions. Not make the decisions, that's where collaboration comes in. But they need to identify key decision points and establish processes that enable timely, collaborative decision-making.
- They need to model change. They need to develop tools to enable/facilitate change in the system, and be early adopters of those tools.
- Most importantly, they need to be seen to listen and to respond to the patients' voice.

We know from Ministry's strategic planning process that many initiatives are planned or already underway that have the potential to greatly assist in this transformation and they are highlighted in our detailed findings. But the critical task of changing how we run the system by including patients, changing incentives and measuring results has only just begun.

While the challenge is immense, the team is bullish on the prospects for significant improvement here in Saskatchewan.

It is clear that Saskatchewan is in a unique position to start this journey now.

The fiscal situation is better than any other province in Canada. Of course there is no blank cheque, but there is room not only to sustain but to invest. That opportunity is even greater if the system builds on the Administrative component of the Patient First Review and seeks opportunity to find savings and efficiencies in administrative and support functions.

As helpful as the fiscal situation is, even more important is the openness and enthusiasm of patients, providers and stakeholders for changes aimed at improvement. Participants were keen to participate in our qualitative discussions during all three phases of the consultation. In many groups, particularly with the stakeholders, participants kept talking with each other after the sessions officially ended. But change by itself can raise as many fears as it raises hopes. Change that aims to deliver the vision that patients have for the system is change welcomed by all participants.

The challenge identified in this review is not to change for change sake, but to improve the system so that it more closely aligns with the patient's vision of the promise of Medicare. So long as the focus of the initiative is to keep the best and fix the rest, we believe this enthusiasm can be sustained. The chances of success will be further heightened if the health system's leaders focus on delivering early results both for patients and providers while building the foundation for longer term cultural and structural change.

The Need for Transformation in Health Care Administration

Report on the administrative component of the Saskatchewan Patient First Review

Prepared by Deloitte

October 2009

PatientFirst

July 17, 2009

Mr. Tony Dagnone, Commissioner,
Saskatchewan Patient First Review

Deloitte is pleased to provide the *Report on the Administrative Review Component of the Patient First Review*. To begin, Deloitte would like to recognize the Government of Saskatchewan's leadership and commitment to understand the challenges in today's health care system, and then take action to make improvements.

The attached Report is the culmination of seven months' effort. During this time, Deloitte has worked closely with Ministry of Health staff, and you to design and deliver this review. In my role as Engagement Partner for this project, I have been part of the core project team and have worked closely with them to digest the findings, summarize the key results, and identify change opportunities that are appropriate for Saskatchewan.

As you will read in this report, the Administrative Review is not just about identifying what is wrong with the system, but rather about building on strengths, understanding causes, and identifying ideas for improvement. In partnership with you and the Ministry of Health staff, we have worked hard to answer the longstanding question related to whether the health care system is 'over-' or 'under-managed' and offer solutions that adhere to the government's 'commitment to action to improve the system'.

This report provides evidence supporting the need for change. It is important that the current political, government and health system leadership of Saskatchewan not overlook the ever-present reality that very little in today's world remains as it was a few decades ago. Saskatchewan and its health care system are not exempt from this global phenomenon. This Government has undertaken a landmark review to improve the system. This report begins the change journey. It will take leadership, commitment and courage.

Throughout this project, we have come to build and enjoy a good and close working relationship with you and the Ministry of Health staff. It has been a privilege to support this critically important initiative to advance the health care system in Saskatchewan.

Sincerely,

Dalton Truthwaite

Dalton Truthwaite
Principal,
Deloitte Inc.

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Glossary of Terms

Term	Description
ADM	Assistant Deputy Minister
AHA	Athabasca Health Authority
BI	Business Intelligence
Current Regional Structure or Service Providers	14 service delivery organizations include the following: 12 Regional Health Authorities, Athabasca Health Authority, and Saskatchewan Cancer Agency
DM	Deputy Minister
ED	Executive Director
eHR	Electronic Health Record
ERP	Enterprise Resource Planning
FTE	Full Time Equivalent
GA	General Administration
HISC	Health Information Solutions Centre
HR	Human Resources
IT	Information Technology
JJE	Joint Job Evaluation
LOS	Length of Stay
LTC	Long-Term Care
MCP	Management Compensation and Classification Plan
MIS Guidelines	Management Information Systems Guidelines
Newco	New Company
Non-urban RHAs	RHAs beyond Saskatoon Health Region and Regina Qu'Appelle Health Region
North RHAs	Athabasca Health Authority, Keewatin Yatthé Regional Health Authority, Mamawetan Churchill River Health Region
PREMIS	Business Intelligence Tool
QBS	Quality as a Business Strategy
RHA	Regional Health Authority
RQHR	Regina Qu'Appelle Health Region
Rural / Urban RHAs	Prairie North, Kelsey Trail, Heartland, Sunrise, Cypress, Five Hills, and Sun Country
SAHO	Saskatchewan Association of Health Organizations
SCA	Saskatchewan Cancer Agency
SHR	Saskatoon Health Region
SMO	Senior Medical Officer
SUN	Saskatchewan Union of Nurses
The Province	The Government of Saskatchewan
Urban RHAs	Regina Qu'Appelle, Saskatoon Health Regions and Saskatchewan Cancer Agency

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Introduction

The Government of Saskatchewan (hereafter called the Province) and the health regions, or regional health authorities (hereafter called RHAs), continue to play a critical role in building and delivering the health care services for Saskatchewan. However, the leadership of the Province and the RHAs will continue to face pressures. Rising costs of care, increasing demand, and the availability and sustainability of the administration workforce are some of the key constraints for which there are neither quick nor easy solutions. Compounding these challenges, citizens expect continued, if not higher, levels of service in spite of these constrained resources. The gap between what is desired and what can be delivered is growing, and will only widen in the current health service delivery environment if changes do not occur. This is the current and growing dilemma for Provincial and RHA leaders.

Within this challenge are the seeds of powerful transformation, which the Province recognizes. Shortly after the election in the fall of 2007, the new government committed to undertake a system-wide Patient First Review of the provincial health delivery system. This commitment is identified as a priority in the November 2007 Mandate Letter for the Minister of Health by the Honourable Brad Wall, the Premier of Saskatchewan. As part of the broader Patient First Review, and with a view to "direct dollars away from bureaucracy" to support enhanced care, the Province through the Ministry of Health (the Ministry) undertook an Administrative Review, which included an assessment of baseline administrative resourcing of RHAs, affiliates, Saskatchewan Cancer Agency, and the Saskatchewan Association of Health Organizations (SAHO).

In seeking to transform the current health care system, there are at least four compelling drivers for examining the administrative component of health care delivery as one of the key elements of the Patient First Review. First, an aggregate view of the health system management provides a unique opportunity to explore innovation and change at the system level, rather than focusing on the individual regional health authority level. Second, the management system is an important player in service planning, decision-making and delivery for patients and communities. Third, the management system today is experiencing the same workforce sustainability challenges evident in the clinical care areas and should be exploring alternative options to maintain quality, efficiency and effectiveness. And finally, the resources allocated for management structure should be dollars well spent, deliver value to the system, and ultimately the patients and communities served. Given the objective of the Administrative Review was to ascertain current levels and determine optimal levels of administrative support for the system, this review has examined the question of whether the current health system is 'over' or 'under' managed, and has identified change opportunities that reflect four key value drivers: patient focus, workforce focus, system focus and overall feasibility.

Introduction

This review reports on how Saskatchewan's health management system compares to other Canadian jurisdictions, and also highlights the current and future sustainability challenges. Through this review, the report does raise the question of value in terms of effectiveness and efficiency of the current regional health structure and its corresponding administrative system. While there are strengths in the system, there are significant challenges. To close the widening gap between expectations, requirements and capabilities, the Province and RHAs will have to acknowledge and endorse a new course of action to manage Saskatchewan's health care system. There are good reasons to change, however, deep change takes time, and suggests urgency for action to allow time for detailed and proactive planning to successfully reshape the management system.

Implicit in the recommendations in this report, Provincial and RHAs leaders must avoid the false notion that the Saskatchewan health sector is too unique, different or constrained to adopt innovative and creative solutions seen in the broader public sector, other health jurisdictions and the private sector. The inevitable conclusion in this report is that the future of Saskatchewan's health system does not lie with the status quo. The transformation opportunities identified are intended to deliver positive outcomes that focus on more effective management, and will ultimately deliver better service and address the sustainability challenges facing many management teams across many of the Regional Health Authorities. An additional and significant benefit in embracing the recommended change is the coming together of RHAs as a common enterprise for select areas of management, rather than a collection of independent entities. The future reduced costs can be used as an offset to the required investment to support the change and, in time, can be re-allocated to the patients and communities of Saskatchewan.

Project Overview

Background

Deloitte was engaged by the Province to conduct the Administrative Component of the Patient First Review, which included an assessment of baseline administrative resourcing of all health regions, or regional health authorities (RHA)s and affiliates, Saskatchewan Cancer Agency, Health Information Solutions Centre (HISC) and Saskatchewan Association of Health Organizations (SAHO). The overarching purpose was to identify if the administrative component of the health system is 'over' or 'under' managed. The areas of focus for this review (the scope) where both qualitative assessment and comparison with other jurisdictions occurred, included: General Administration (GA), Finance, Human Resources (HR), and Information Technology (IT). In the qualitative and comparative analysis, the objectives were to:

- Identify current levels of administration support;
- Determine optimal levels of administration support;
- Identify if the current structures are over or under resourced;
- Assess enablers and barriers of system effectiveness; and
- Identify improvements or alternatives that could enhance system value.

In addition, Telehealth and Nursing Management were two further areas for review that were primarily qualitative in nature:

- Telehealth encompassed a review of utilization related to clinical, education and administrative applications, and an identification of areas for improvement; and
- Nursing Management assessed the current span of control issues and identified enablers and barriers for Nurse Manager effectiveness in acute care and integrated health facilities, followed by improvement opportunities. The Project Sponsors recognized the challenge in excluding the community, long term care, public health and home care sector for this component of the review. However, given the budget limitations, and the belief that findings from the review would be applicable to all sectors, the focus was the acute domain with the agreement to share the acute findings with the remaining sectors to explore alignment and relevance.

It is important to note that the intent of this review was to assess the management function and resourcing at a province-wide level. While the review began by understanding the relevant areas in each RHA as well as other relevant provider entities, such as SAHO, SCA and HISC; individual provider information was combined to provide an aggregate baseline for comparison against other jurisdictions. This macro approach offers Saskatchewan a 'big picture' understanding, and was intended to drive opportunities for system benefit rather than focusing at the individual RHA provider level.

Due to the province-wide focus of the review, and the strong linkage to administration functions, the area of supply chain management was considered within the review.

Limitations

The findings through this review do not report information at the RHA or affiliate level. In particular, affiliate data at the RHA level was part of the RHA summary data that was further aggregated for a provincial picture. The aggregate nature of this review provides findings that may stand in contrast to comparative analysis conducted at the individual level RHA. This is an important consideration when RHAs compare the results against their own individual benchmarking exercises conducted in other reviews.

External scan participants provided a wide range of information to support Saskatchewan's change journey. However, the sensitive nature of some of the provided information and intended direction for their jurisdiction prevents disclosure of their identity.

This report is intended for internal use by the Ministry of Health and the Government of the Province of Saskatchewan; it is not designed for external purposes or third parties. This document is to assist in the development of future planning, budgeting, funding and reporting requirements for health services in Saskatchewan.

The recommendations are based on data collected and validated, analysis conducted, and consultations with key stakeholders. Deloitte is not responsible for updating the analysis or the report following the submission of this report.

Consulting Process

There were four phases in this project. All phases of work were supported by consultation and collaboration with the Patient First Commissioner – Mr. Tony Dagnone, and Project Lead for the Ministry of Health.

Phase 1 – Project Launch and Planning provided the foundation for the Review and focused on: confirming the project scope and workplan, developing a detailed stakeholder engagement strategy, planning the consultation sessions, distributing program profile questionnaires to participating organizations and a data request to the Province for information available centrally (i.e. strategic / operationally plans, financial and payroll information, etc).

Project kick off meetings were held to confirm project scope, approach, timelines, responsiblities, and data requests.

Phase 2 – Current State Assessment focused on a combined quantitative and qualitative process conducted in following areas: 13 RHAs (including Athabasca Health Authority), SAHO, SCA, HISC. At the Service Provider level, the focus was on the specific areas of: General Administration, Finance, Human Resources, Information Technology, Nursing Management (acute and/or integrated facilities) and Telehealth. While no affiliates were interviewed (see below), affiliates within the current RHAs were included within the quantitative analysis. Understanding the delivery of these services at the respective provider level was key before rolling up data to conduct province-wide analysis for General Administration, Finance, Human Resources, and Information Technology. For the Nursing

Management and Telehealth work streams, there was a focus on the current barriers for effectiveness and required enablers for improvement.

Given SAHO's role in procurement for the Province, and the material relevance of Supply Chain as a corporate support function, high level analysis of Supply Chain was undertaken, although this was not in scope for a detailed review at the RHA level. Potential opportunities related to supply chain were considered given the natural linkages to the Finance function through accounts payable, and the provincial group purchasing function supported by SAHO.

The following methods were used to provide an understanding of operating context as well as to validate accuracy of the administrative baseline.

Qualitative research and analysis

- Consultations with leadership and management across:
  - RHAs, SCA, SAHO, HISC
  - A sample of 5 RHA-selected affiliate leaders selected from across the province
  - A sample of 6 current / exiting board chairs
  - Leadership in the Ministry of Health (Assistant Deputy Minister and Executive Director level)
- Profiles relevant to General Administration, Finance, Human Resources, Telehealth and Information Technology were completed by RHAs, the Cancer Agency and SAHO in advance of the consultation, and were used to augment the interview process
- Web-based survey of 226 Nurse Managers in acute and integrated care facilities to gain insights on their span of control issues with a 51% response rate
- Focus groups with Nurse Managers to understand their span of control and related operational challenges. Interviews with Directors and Clinical Vice-presidents were also conducted to further validate the scope of the Nurse Manager role, and the associated challenges.
- Literature review on Nurse Management span of control
- Management focus groups as internal customers of Finance, Human Resources, Information Technology and General Administration services
- Review of relevant background documentation (Strategic Plan, Performance Reports, etc) provided a basis for consultation meetings
- Identification of strengths and challenges related to current processes, practices and requirements were documented through consultation

Data analysis and validation

- Application of national reporting standards (i.e. Management Information System (MIS) guidelines) for the purposes of internal trending and external benchmarking;
- Validation of RHA and Cancer Agency data facilitated by the Ministry's MIS coordinator
- Inclusion of HISC, SAHO, and Cancer Agency relevant costs for provincial roll-up data analysis;
- Comparison of Saskatchewan to the following Canadian jurisdictions: British Columbia, Alberta, Manitoba, Ontario, Nova Scotia, New Brunswick, Newfoundland and Labrador; and

- Internal trending / analysis, where data was grouped as follows:
  - Saskatchewan-wide – all entities;
  - Urban – Saskatoon Health Region, Regina Qu'Appelle Health Region, Saskatchewan Cancer Agency;
  - North – Athabasca Health Authority, Mamawetan Churchill River RHA, and Keewatin Yatthé Health Region; and
  - Rural/Urban – All other regional health authorities (8).

External Scan

(interviews and research of other Canadian and international jurisdictions) to further inform comparative analysis, identify trends and gain insights on key issues relevant to Saskatchewan:

- On completion of the consultation and high level data analysis, the project team identified key issues of focus for inclusion in the external scan;
- Key issues of focus and other jurisdictions for inclusion were validated with the Project Sponsors and Patient First Commissioner. Topics included alternate service delivery models and benchmarking; and
- Interviews were conducted with leaders (either in RHAs or in other Canadian Provincial Ministries of Health) across British Columbia, Alberta, Ontario, and New Brunswick. Through Deloitte's 'Knowledge Exchange' and network of health care industry leaders globally, additional research was conducted that included Manitoba, Nova Scotia, the United States, the United Kingdom, and Denmark.

Phase 3 – Opportunity Assessment and Identification involved the presentation of findings and opportunities for Saskatchewan's health system to the Project Steering Committee.

The consulting process included a two-step process. At the first Steering Committee meeting, preliminary findings and opportunities were presented. The opportunities were categorized as enabling and transformational. For several of the transformational opportunities, additional analysis was conducted and the results presented at a second Steering Committee.

This two step process allowed the Steering Committee time for reflection on the findings and opportunity areas, as well as additional high level analysis to determine the preferred direction for those areas of significant change (called the transformational opportunities).

Phase 4 – Recommendations and Final Reporting involved the development of draft and final reports supported by the Patient First Commissioner and Ministry feedback. Assessment findings, opportunities, and implementation considerations are included in this final report.

Throughout the lifespan of the Administrative Review, the Deloitte Project Team engaged with respective teams for the Patient Experience Component (KPMG) and the Legislative Secretariat for Nursing Recruitment and Retention. Through such collaboration, the respective projects were able to facilitate information sharing and validation and explore areas of alignment.

Key Findings and Associated Implications

Combined Corporate Management or "Administration" (i.e. General Administration, Finance, Human Resources, Information Technology)

Saskatchewan's Corporate Management system has much strength to build upon. Over the years, Ministry of Health and RHA leaders have established forums where they convene to collaborate and provide inter-organizational support. Examples of such initiatives include:

- Health Quality Council - applying key lessons from high performing health systems (i.e. Quality as a Business Strategy, Lean, Releasing Time to Care);
- Leadership Forums – CEOs, Chief Information Officers / IT Leaders, Senior Medical Officers, Workforce Planning, Nursing;
- South Regions Forum (comprised of RHAs in southern Saskatchewan); and
- Northern Health Strategy (for Saskatchewan).

Despite these collaborative efforts and successes, challenges within Corporate Management continue to grow. Moreover the resource base and capacity across the RHAs in Saskatchewan is highly variable, thereby creating significant differences in these service providers' responses to the growing pressures in the area of Corporate Management. Throughout our consultation, major issues of workforce and fiscal sustainability were raised, in particular amongst the non-urban RHAs across corporate areas (i.e. Finance, HR, and IT).

Benchmarking Comparison

Metric	Sask-wide	Canadian Peers		
		25th %ile	Median	75th %ile
% of Operating Spend	6.51%	5.80%	6.91%	7.86%
Admin Spend / Health Region (000s)	$12,308	$14,480	$20,940	$80,739

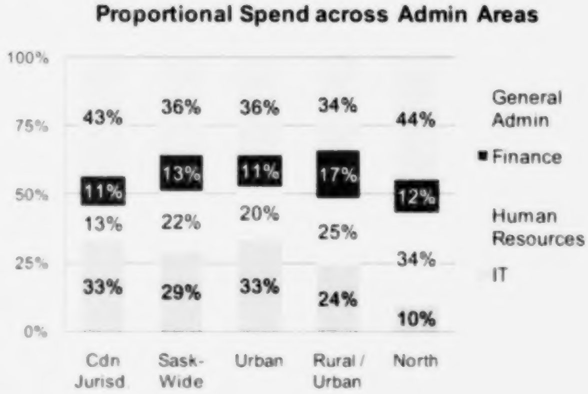
A starting point for analysis was to review the overall combined Administration Spend across the four Administration areas (i.e. GA, Finance, HR, and IT) to determine how these components of Saskatchewan's overall corporate management resourcing compares to other Canadian provinces.

Results show that at a combined level (for all four areas), Saskatchewan is below the Canadian median, which means it is spending less than other Canadian jurisdictions on Administration as a percentage of total operating spending. The combined overall lower percentage of total operating spend for Administration repudiates the concern somewhat that Saskatchewan is spending more resources on Administration than other jurisdictions.

While on the surface, this appears a 'good news' finding, subsequent analysis in this report demonstrates that there are variations in resourcing levels at the discrete functional levels of General Administration, Finance, Human Resources and Information Technology. As health care organizations in Saskatchewan target a 5% Administration spend overall, strategic investments (such as HR to address workforce challenges) require trade-offs in relative investment in other key areas of need (i.e. IT to advance the eHealth agenda). Further discussion on the specific areas will be reported on in the remaining sections of this report.

On closer review of the proportional spend across Administration areas; there is also variation across the province. Compared to other Canadian jurisdictions:

- Saskatchewan's urban RHAs are in line in IT and Finance;
- Saskatchewan's rural/urban RHAs are below in IT and GA, but over in Finance and HR; and
- Saskatchewan's northern RHAs are below in IT, in line with GA and Finance, and over in HR.


Proportional Spend across Admin Areas

Implications

While Saskatchewan shows lower levels of corporate spend when combining all functions (General Administration, Finance, Human Resources and Information Technology) in contrast to other Canadian jurisdictions, this report is not stating that the lower spend represents efficiency and effectiveness.

The consequence of lower relative spend is that Regional Health Authorities in Saskatchewan, particularly in the Non-urban RHAs, are experiencing significant performance challenges (from a customer needs perspective) and sustainability challenges (from a fiscal and workforce perspective). Our consultation indicates that many areas of management support (such as: quality, performance management, decision support, patient safety, project implementation support and strategic human resource management, etc) are not occurring at the level that they should, when compared to the needs of the respective organizations. The inability to provide adequate services in these areas creates real limitations to effective management support and function. Improvements in these corporate management areas across the province, while desirable, are not feasible given the current regional structures and associated resourcing.

Two important questions surfacing from this review for broader provincial consideration are:

- "Is Saskatchewan receiving desired value for its corporate spend on Administration across its multiple RHAs and SCA?"
- "What would a higher value regional model and structure look like for Saskatchewan in terms of more efficient Administration spending?"

While on the surface, this appears a 'good news' finding, subsequent analysis in this report demonstrates that there are variations in resourcing levels at the discrete functional levels of General Administration, Finance, Human Resources and Information Technology. As health care organizations in Saskatchewan target a 5% Administration spend overall, strategic investments (such as HR to address workforce challenges) require trade-offs in relative investment in other key areas of need (i.e. IT to advance the eHealth agenda). Further discussion on the specific areas will be reported on in the remaining sections of this report.

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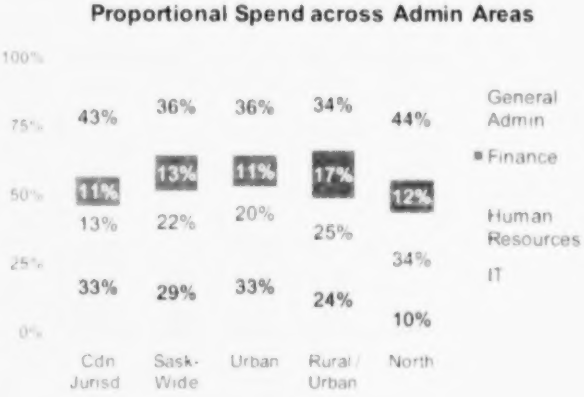
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- "Is Saskatchewan receiving desired value for its corporate spend on Administration across its multiple RHAs and SCA?"
- "What would a higher value regional model and structure look like for Saskatchewan in terms of more efficient Administration spending?"

Related to the first question, Saskatchewan would benefit from a future corporate health management structure that achieves a balanced mix of strong, centralized management of Administration, combined with local responsiveness designed to:

1. Create economies of scale through a centralized procurement function and the consolidation of repetitive transactional functions occurring across all RHAs;
2. Promote standardized practices for current and new work processes to enhance effectiveness;
3. Attract and retain required staffing for 'hard to find roles' to avoid the current and anticipated workforce challenges in many of the RHAs; and
4. Provide consistent strategic leadership at a province-wide level.

Such a management transformation of the Administration function is intended to deliver higher value, address sustainability challenges across smaller regions, increase efficiency, and, once in place, costs the system less. Operating dollars saved through transformation can be re-allocated to the patients and communities of Saskatchewan.

In terms of the second question, the Province will require further review and planning in order to design a different regional health model. This review did not examine the current Regional Health Authority structure. Consequently, the comments made in this report relate to the number of RHAs in Saskatchewan and their respective impact on resource distribution in the area of Administration. While 13 entities may align to the geographic dispersion of Saskatchewan's population, economies of scope and service quality related to Administrative services, are hampered by the distribution of a limited pool of resources (i.e. financial and people). Provinces across Canada continuously examine this issue and there are numerous lessons to be learned from Provinces that have embarked on changes to their health care structures.

Finance

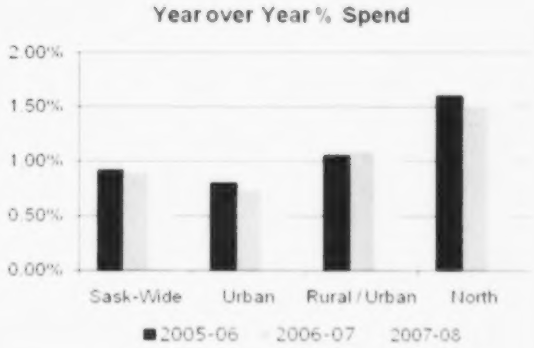
In this review, the Finance function included the following areas: Accounts Payable and Receivable, Payroll, Budgeting, General Accounting, Financial Reporting and Planning.

The two charts shown below indicate the spend variation at a function-specific level that deviates from the overall combined trend for all four areas. In the lower left hand table titled, "Year over Year % Operating Spend", the relative spend on Finance has been declining – which indicative of higher relative spending in other areas of the health care organizations (i.e. clinical services).

The second analysis table titled "Benchmarking Comparison" compares Saskatchewan to Canadian jurisdictions. It shows that Saskatchewan's level of resourcing in Finance is relatively higher than peers. Our consultation findings suggest that this variance is driven by:

- Manual processes and lack of automation (i.e. Procure-to-Pay electronic enablement, Business Intelligence tools); and

- The current regional structure of 14 entities – where economies of scale and scope are difficult to achieve given that regions are performing similar functions.



Benchmarking Comparison

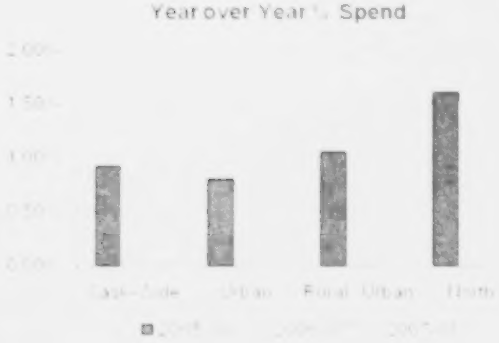
Metric	Sask- wide (07-08)	Canadian Peers (06-07)		
		25th %ile	Med	75th %ile
% of Operating Spend	0.85%	0.63%	0.74%	0.80%
Finance Operating Cost / Org. FTEs	$798	$633	$720	$876
Org. FTEs / Finance FTEs	80	75	90	99

While the current regional structure (meaning the number of entities) may drive the higher provincial benchmark result relative to other provinces, the real challenge is that the non-urban regions are primarily transaction focused with limited ability for higher function requirements. Our analysis indicates that approximately 60% of Finance operating FTEs are in transactional functions (such as Accounts Payable, Accounts Receivable, General Accounting, Asset Management, and Payroll) with limited support capacity to support strategic management (planning / analysis / decision support functions).

Consistent with findings reported in GA, HR and IT, Finance departments also report current and anticipated gaps in recruiting qualified staff. Specifically, eight regions indicated current vacancies, and six regions indicated recruitment challenges of qualified staff. The consequence is that Chief Financial Officer (CFO) and / or Director roles in the non-urban RHAs are often required to perform frontline functions / activities (i.e. decision support and analysis). The larger total operating base for urban RHAs enable Saskatoon Health Region and Regina Qu'Appelle Health Region to build capacity and invest in Finance to support activities such as process automation through Business Intelligence (BI) Tools and Financial Analyst / Business Manager roles. Such resources are, generally, not available to the smaller Regions. However, the maturity level of BI tools is limited by available information – which is primarily financial or payroll based. With limited linkages to statistical / clinical utilization data, budget accuracy, funding, and in-year performance management are impacted – and may not meet the needs of RHAs and the communities they serve. Smaller RHAs have developed manual processes and home-grown tools for performance reporting where managers have to go to multiple sources (including paper-based to access performance reports), which further dilutes manager time and creates the risk of inconsistent reporting.

Also significant is that internal customers of Finance (Managers interviewed in focus groups) report limited Finance department support / capacity to deal with budgeting, planning, and ongoing management throughout the fiscal year. Similarly, support for education and training related to information / tools, and expectations of managers were reported to be inconsistent. Internal customers (i.e. managers) did report that they did not believe Finance

- The current regional structure of 14 entities – where economies of scale and scope are difficult to achieve given that regions are performing similar functions.



Benchmarking Comparison

Metric	Sask- wide (07-08)	Canadian Peers (06-07)		
		25th %ile	Med.	75th %ile
% of Operating Spend	0.85%	0.60%	0.74%	[illegible]
Relative Operating Cost / Org. FTEs	$798	[illegible]	$720	[illegible]
Org. FTEs / Finance FTEs	80	75	90	90

While the current regional structure (meaning the number of entities) may drive the higher provincial benchmark result relative to other provinces, the real challenge is that the non-urban regions are primarily transaction focused with limited ability for higher function requirements. Our analysis indicates that approximately 60% of Finance operating FTEs are in transactional functions (such as Accounts Payable, Accounts Receivable, General Accounting, Asset Management, and Payroll) with limited support capacity to support strategic management (planning / analysis / decision support functions).

Consistent with findings reported in GA, HR and IT, Finance departments also report current and anticipated gaps in recruiting qualified staff. Specifically, eight regions indicated current vacancies, and six regions indicated recruitment challenges of qualified staff. The consequence is that Chief Financial Officer (CFO) and / or Director roles in the non-urban RHAs are often required to perform frontline functions / activities (i.e. decision support and analysis). The larger total operating base for urban RHAs enable Saskatoon Health Region and Regina Qu'Appelle Health Region to build capacity and invest in Finance to support activities such as process automation through Business Intelligence (BI) Tools and Financial Analyst / Business Manager roles. Such resources are, generally, not available to the smaller Regions. However, the maturity level of BI tools is limited by available information – which is primarily financial or payroll based. With limited linkages to statistical / clinical utilization data, budget accuracy, funding, and in-year performance management are impacted – and may not meet the needs of RHAs and the communities they serve. Smaller RHAs have developed manual processes and home-grown tools for performance reporting where managers have to go to multiple sources (including paper-based to access performance reports), which further dilutes manager time and creates the risk of inconsistent reporting.

Also significant is that internal customers of Finance (Managers interviewed in focus groups) report limited Finance department support / capacity to deal with budgeting, planning, and ongoing management throughout the fiscal year. Similarly, support for education and training related to information / tools, and expectations of managers were reported to be inconsistent. Internal customers (i.e. managers) did report that they did not believe Finance departments to be purposely unresponsive, rather that workload pressures require Finance staff to prioritize and hence the internal customer needs may not be met in a timely manner.

Given such people and process challenges, it is not surprising that the area of data management is an area of concern across the province. While all organizations have a chart of accounts, data definitions and common accounting policies, there are significant differences across organizations. Such variation makes inter / intra-provincial comparisons a challenging task. For example; in completing this project, more than 300 adjustments were made to Saskatchewan data across RHAs / Other Providers. Quality data, reporting requirements and lack of decision support tools impact the value Finance can deliver to organizations.

While Supply Chain was not in scope, the review did conduct some high level analysis for two reasons: 1) accounts payable has significant linkage to the supply chain function, and 2) group purchasing is a key support function provided by Saskatchewan Association of Healthcare Organization (SAHO) to RHAs. The annual provincial spend on supplies (i.e. medical / surgical, drugs, diagnostics and therapeutics, minor equipment, and capital) was $420 million annually in 2007-08. SAHO group purchase contracts account for 20-25% of spend across both operating and capital spend items. Given the duplication of supply chain functions across the RHAs, and the total annual spend to manage the supply chain function is approximately $13.5 million (i.e. compensation and non-compensation costs to manage the supply chain), this area is worth further investigation in Saskatchewan as an area of potential cost savings. For health care organizations across Canada and internationally, end-to-end supply chain is a key area of focus for service integration, and can offer invaluable lessons for supply chain delivery in Saskatchewan.

Implications

The higher resourcing of Finance relative to other Canadian jurisdictions, workforce sustainability challenges, and the high transactional nature of work, suggest that it is a reasonable candidate to explore the degree to which an alternative service delivery model can deliver efficiency and capacity opportunities.

As well, a similar opportunity for alternative service delivery presents itself related to Supply Chain. Across Canada, many jurisdictions indicate that a positive business case for Supply Chain service integration can support service integration across other corporate and support functions.

Human Resources

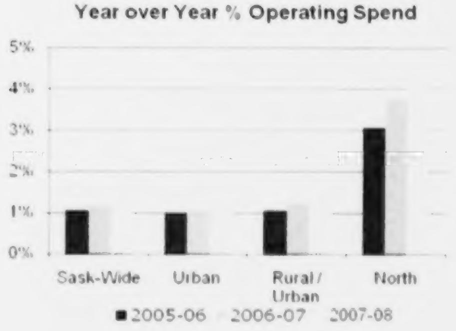
In this review, the Human Resource (HR) function included the following areas: HR Administration, Labour / Employee Relations, Occupational Health and Safety, Organizational Development, Talent Management, and Benefits Management.

To meet the people needs of the organizations, Human Resources departments must continually evolve to both meet current human resource requirements, while anticipating and planning for future needs. Traditional HR provided services have not evolved across Saskatchewan to meet these needs, particularly in the non-urban regions. This is further compounded by the lack of an HR information system (HRIS) creating work at many levels of the organization that is paper based and labour intensive.

The two charts shown below indicate the spend variation at a function-specific level that deviates from the overall combined trend for all four areas. In the lower left hand table titled, "Year over Year % Operating Spend", Saskatchewan's HR spend as a percentage of total operating spend continues to increase at a significant and unsustainable rate due to domestic and international recruitment efforts required to keep health care facilities and clinical programs operating.

Further, as shown in the second analysis table titled "Benchmarking Comparison" which compares Saskatchewan to Canadian jurisdictions, Saskatchewan's level of resourcing in Human Resources is relatively higher than peers. Consultation findings suggest that this variance is driven by:

- Significant provincial investment to sustain current clinical programs / infrastructure – through an increased focus on nursing recruitment domestically and abroad;
- Increasing demands placed on HR functions across Saskatchewan's health care organizations to support increased recruitment requirements, and to address employee safety / wellness with an aging workforce;
- Complex collective agreements that reportedly (by management and leadership) requires both local support through Labour Relations advisors (38 FTEs across health care regions) to manage day-to-day operations, and provincial expertise and support through SAHO's provincial Labour Relations team (22 FTEs);
- Manual processes and a lack of automation across HR functions (i.e. a Human Resource Information System currently exists in only 1 RHA); and
- The current regional structure (14 entities) makes economies of scale and scope difficult to achieve.


Year over Year % Operating Spend

Benchmarking Comparison

Metric	Sask-wide	Canadian Peers			Other Jurisdictions & Industries (50th %ile)	
		25th %ile	50th %ile	75th %ile	US Health Care	Banking
% of Operating Spend	1.43%	0.81%	0.89%	0.95%	N/A	N/A
HR Operating Cost / Org. FTEs	$1,341	$699	$892	$1,197	$892	$1,695
Org. FTEs / HR FTEs	104	82	116	118	140	83

Generally, our consultation findings indicate that HR departments have varying skill sets and capacity, which impacts their ability to address strategic priorities. Similar to Finance, the magnitude of the urban RHAs operating bases (specifically Saskatoon and Regina Qu'Appelle Health Regions) allows for a higher level of investment in HR, and enables increased strategic focus, capacity building and investment to support initiatives such as:

succession planning, leadership development, integrated HR service teams, and workplace culture. However, across much of the province, the current HR service delivery model is not meeting the needs of the growing, complex health environment. Frontline managers indicate that while they receive support from HR across the various functions (i.e. recruitment, disability management, attendance management), the level of support is insufficient. Moreover, HR departments have limited mechanisms to measure or monitor customer service quality, satisfaction and requirements, thereby creating a disconnect between services provided and services needed. Internal customers did report that they did not believe Human Resources Departments to be purposely unresponsive, rather that workload pressures require Human Resources staff to prioritize and hence the internal customer needs may not be met in a timely manner.

SAHO has a significant role supporting the HR function in the province. It provides support for provincial collective bargaining, labour relations expert advisory support, training and other organizational supports for member organizations (such as Career Pathing, Representative Workforce, Occupational Health and Safety). Such shared services provided by SAHO continue to provide value to the system, as reported to us by SAHO's member organizations and the Ministry of Health.

Implications

The higher relative resourcing of Human Resources compared to other Canadian jurisdictions combined with the workforce sustainability challenge, the high transactional nature of work and limited capacity for strategic initiatives suggest that it is a reasonable candidate to explore the degree to which an alternative service delivery model can deliver efficiency and capacity opportunities. Where alternative service delivery models are examined, it will be important to consider and build upon the important provincial HR functions that are currently supported by SAHO.

Information Technology

In this review, the Information Technology (IT) function included the following areas: Help Desk, Network / Infrastructure Support, Application Support, Project Support, Technology Support and Systems Engineering / Development.

Each organization reviewed had an IT function; however, there are various service delivery models in place. Generally, where IT functions in RHAs have not been sufficient to meet business requirements due to a range of issues (such as: recruitment challenges, skill base of current staff, capacity of existing staff, escalating costs to support / enhance infrastructure and processes), the RHAs have adopted alternative service models. For example, two RHAs have contracted with external providers through outsourcing agreements, and three RHAs obtain IT services through a managed service relationship with other RHAs.

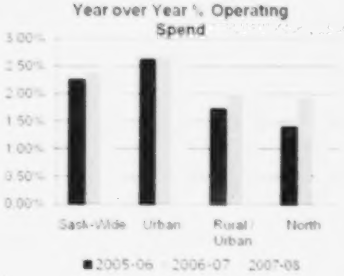
A key component of IT in Saskatchewan's health care is the support provided by Saskatchewan Health Information Network (SHIN). SHIN is a Treasury Board Crown Corporation that is accountable to, and funded by the Ministry of Health. SHIN's mandate is managed and delivered by the Health Information Solutions Centre (HISC), and includes the following key roles:

- Deliver the mandate of an Electronic Health Record for Saskatchewan citizens;
- Support health sector initiatives within the IT domain;
- Provide a secure province-wide health information network, including hosting health care applications centrally through the HISC data centre; and
- Provide information management and technology services to regional health authorities and other health service providers and delivery agencies within Saskatchewan.

While HISC supports all RHAs, non-urban RHAs are larger users of HISCs service offerings.

As part of the comparative analysis (benchmarking) exercise for IT in Saskatchewan, in addition to the Canadian provincial comparison, the review included an assessment of relative investment levels in non-Canadian health care organizations and other industries. US health care organizations and other knowledge-based industries spend more than 5% of their operating budgets on Information Technology (IT). Leading health service organizations in the US indicate that they spend more than 7% annually on IT.

The two charts shown below indicate the spend variation at a function-specific level. In the lower left hand table titled, "Year over Year % Operating Spend", Saskatchewan's IT spend as a percent of total operating spend is increasing. This trend demonstrates the 'catch-up' phenomena.


Year over Year % Operating Spend

Benchmarking Comparison

Metric	Other Jurisdictions & Industries (50th)				Sask-wide	Canadian Jurisdictions		
	US Health Care	Banking	Insurance	Government		25th %ile	50th %ile	75th %ile
% of Operating Spend	5.4%	12.6%	7.1%	6.8%	1.90%	1.87%	2.55%	2.71%
IT Operating Cost / Org. FTEs	N/A	N/A	N/A	N/A	$1,779	$1,751	$2,365	$3,162
IT Operating Cost / Org. Headcount	$10,498	$24,391	$24,823	$11,467	$1,229	N/A	N/A	N/A

In spite of the 'catch-up' trend, as shown in this second analysis table titled "Benchmarking Comparison", Saskatchewan remains below all comparators – either Cana Management section of this report. Further, when examining the relative proportional dian provinces or other international health jurisdictions and industries. This lower spend is a key driver in the lower combined spend result as shown earlier in the overall combined Corporate Provincial spend on capital versus operations, the ratio is 17% (capital) to 83% (operational) for Saskatchewan. This stands as a noted contrast to US health providers whose same ratio is 30% to 70% respectively.

Within Canada, Canada Health Infoway (CHI) recommends 4% annual spend on IT to achieve the potential and desired benefits in quality, access, and productivity. Analysis shows that Canadian jurisdictions, including Saskatchewan, are spending below broader industry averages, and all provinces continue to 'catch-up' regarding spending on IT infrastructure for clinical and non-clinical information systems.

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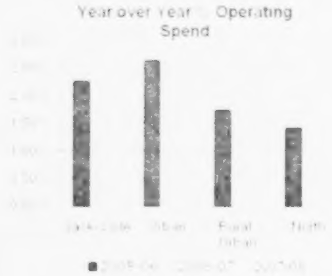

Benchmarking Comparison

Metric	Other Jurisdictions & Industries (50th)				Sask-wide	Canadian Jurisdictions		
	US Health Care	Banking	Insurance	Government		25th %ile	50th %ile	75th %ile
[illegible] Operating Spend	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
IT Operating Cost [illegible]	N/A	N/A	N/A	N/A	[illegible]	[illegible]	[illegible]	[illegible]
IT Operating Cost [illegible]	$10,408	[illegible]	[illegible]	[illegible]	$1,220	N/A	N/A	N/A

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Saskatchewan's lower comparative analysis results point to the need for continued investment in IT as an important requirement for two important considerations that:

1. Advance the eHealth agenda; and
2. Support the eHealth uptake and stronger business and clinical management among RHAs.

Consultation findings indicate that non-urban RHAs are largely unable to meet business and clinical information needs of their organization and that the levels of IT support and competency is highly variable across the province. Saskatchewan's RHAs report that the 5% cap on administration spending (including GA, Finance, HR, and IT) impacts their decision making ability related to investment in IT – suggesting that administration spending targets may either need to be adjusted (or should exclude IT) to remove perceived barriers to investment and support more accurate reporting. (Note: RHAs have historically been required to maintain Administration Spending within 5% of total operating spend.)

A further concern is that the future situation will be even bleaker where RHAs do not have the IT capacity to support the upcoming clinical transformation needed in moving to an eHealth environment, a stated objective of the Ministry of Health.

Implications

The Province will have to overcome its IT investment fatigue and recognize that, in spite of funding support in recent years, it continues to under-invest in IT. Additional support is required to advance the eHealth shift as well as support enhancement of clinical and business process requirements for the RHAs.

Future investments should be grounded in both:

- eHealth Strategic plan (which is underway) to guide Provincial and RHA priorities; and
- Defined RHA requirements for operations (business, information and clinical).

The Province should avoid the distributed service model seen in Finance and HR where there is duplication across regions, recruitment of qualified staff is a challenge and the limited critical mass furthers service and sustainability pressures. These challenges are only to be repeated in IT where RHAs attempt to build their own enhanced IT service response.

Looking forward, the role of HISC remains pivotal, however further review is required to determine changes at the HISC level in terms of how it supports RHAs and other organizations in the system (mandate, roles, services offered). Moreover, through consultations, a need was identified by stakeholders for stronger coordination and collaboration in IT strategy development, service planning and implementation.

General Administration

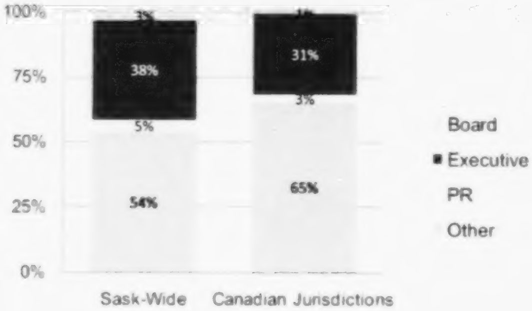
In this review, the General Administration (GA) function includes the following areas: Executive, Board, Public Relations, Infection Control, Strategy / Planning / Decision Support, Quality, Risk, and Patient Safety.

Key Findings

The two charts shown below provide results at a function-specific level. In the lower left hand table titled, "Proportional Operating Spend by Area", Saskatchewan is spending more proportionally on Boards and Executive Management. The higher spend on Executive and Board is driven by non-urban RHAs, and is related to the relatively small total operating costs over which GA costs are spread. In dollar terms, the annual spend for Boards is reported to be $1.7M annually. In addition to this dollar cost, there is significant time and effort spent by executive teams (i.e. RHA CEO's, VPs, and CFO's) related to Board support.

Further, as shown in this second analysis table titled "Benchmarking Comparison" which compares Saskatchewan to Canadian jurisdictions, Saskatchewan is spending less in this area than other provinces. The consequence of lower spend in GA means fewer available resources in non-urban regions for key support functions, such as: strategic planning, decision support, quality, risk, patient safety, corporate project management support, medical affairs, infection control and the sustained implementation of provincial initiatives.

Proportional Operating Spend by Area



Benchmarking Comparison

Metric	Saskatchewan	Canadian Peers		
		25th %ile	Median	75th %ile
% of Operating Spend	2.30%	2.82%	2.99%	3.55%
Operating Cost / FTE	$2.131	$2.565	$2.699	$3.734
GA Spend / Health Region (000s)	$4.371	$7.323	$10.168	$33.518
GA Spend / Capita	$60	$59	$65	$71

Consultation findings suggest that challenges in attracting and retaining executives at the RHA level will continue as approximately a quarter (or 26%) of this group are eligible for retirement in 5 years. Moreover, the review found that there are limited succession strategies in place to address this high level of turnover.

Additionally, recruiting physician leadership is challenged in the non-urban RHAs given that these roles are only part-time (0.2 to 0.5 FTE across most non-urban regions), and have limited support or capacity for activities, such as physician recruitment / retention and resource planning, quality of care initiatives, enforcing standards of care / practice, physician performance management and accountability.

Implications

The lower relative GA spend has consequences for RHAs in Saskatchewan, particularly amongst the non-urban RHAs where there is limited ability to invest in the areas of performance management, quality, patient safety, risk management and decision support. These limitations converge to create performance, accountability and sustainability challenges.

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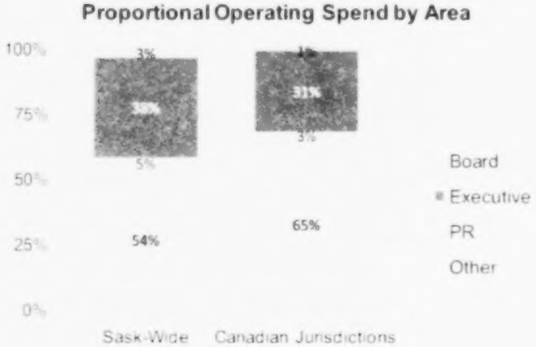

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Implications

The lower relative GA spend has consequences for RHAs in Saskatchewan, particularly amongst the non-urban RHAs where there is limited ability to invest in the areas of performance management, quality, patient safety, risk management and decision support. These limitations converge to create performance, accountability and sustainability challenges.

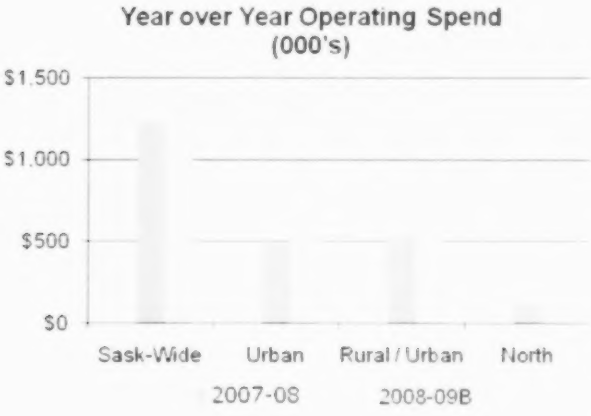
The requirements to provide robust levels of management support across the larger number of health regions would be cost prohibitive. Moreover, the value in duplicating these resources across all RHAs is questionable suggesting the need for future review of the overall regional model.

Regardless of the number of RHAs, current management teams should assess the requirements of their senior management teams to ensure the best allocation and distribution of resources – where reallocation of resources should consider requirements to enhance quality, safety, access, and ultimately, the patient experience.

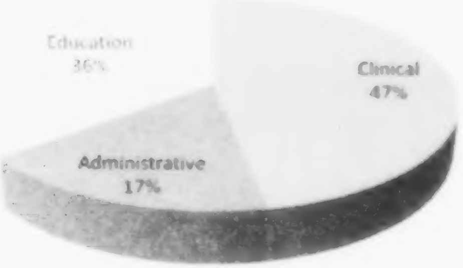
Finally, Physician leadership challenges require leader and support roles at the RHA level beyond the current level of resource investment to increase capacity for key activities such as physician resource planning, quality of care initiatives, and physician performance management and accountability.

Telehealth

Telehealth enables the delivery of health related services and information through the application of telecommunications. Telehealth in Saskatchewan is a provincial program that is currently part of HISC, and has been in place since 2004. Key objectives include: Improved access to health services and health care providers; Enhanced rural practice support; Encourage optimal use of health care providers; and Provision of continuing education and health information to patients and the public. Both provincial and RHA investment in capital equipment (i.e. Telehealth suites and technology) and Telehealth operations (i.e. Telehealth coordinators in each RHA) has fostered continued growth in the program. As shown in graphic (above), year over year operating spend from 2007-08 to 2008-09 increased 14%. Analysis of data (not shown) indicates that Telehealth sessions (all types) have increased to approximately 4000 in 2007-08, which is more than double since 2004-05.



While use and investment in Telehealth is growing, there is high potential for continued expansion for clinical, education, and administration utilization. Within Saskatchewan, Telehealth continues to be an under-utilized resource to support alternate service delivery models for patient care, as well as staff education and management / administrative uses.



Telehealth Utilization 2007/08

The graphic (at right) outlines the distribution of Telehealth use by type: 47% for clinical (patients), 36% for staff education, and 17% for administrative (meetings and teleconferences). This shows that clinical utilization represents nearly half of the all the Telehealth utilization, which is a good direction. Notwithstanding the gains, there are reported challenges with coordination, scheduling and delivering clinical sessions, and limited staff and technology resources. All of these challenges make it difficult for service expansion. Where Telehealth continues to be cumbersome from a physician / clinician perspective, this technology will have sustainability challenges – where physicians will discontinue use of Telehealth in favor of more traditional clinical care (i.e. in-person consultations).

Implications

Telehealth is a key enabler to increasing access to specialty services across a province like Saskatchewan – which has large geography, dispersed populations, and challenges recruiting specialists to non-urban areas.

This area of review has a more direct linkage to the Patient Experience review. More specifically, Telehealth can continue to address some of the reported access challenges that were highlighted in focus groups across the province.

Both capital and operating investment is required to sustain and expand Telehealth use in Saskatchewan, and to design and support work processes (i.e. scheduling coordination) and technologies (i.e. desktop video conferencing, video archiving) that will make it easier to access / use.

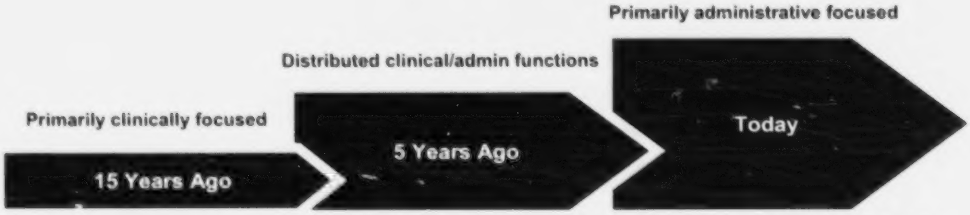
Seamless applications of Telehealth from a care perspective, without time / financial impacts to physicians, are key requirement for increased clinical uptake by physicians. Success in this application will support other Telehealth applications being used in other jurisdictions (i.e. tele-home care, telemonitoring) that can be considered.

Nursing Management

The Nursing Management focus in this review was to gain a better understanding of span of control issues, as well as the enablers and barriers for Nurse Manager effectiveness in acute units and integrated health facilities (acute and long term care).

Our findings reveal nursing management roles in Saskatchewan, like the rest of Canada, have evolved over the past two decades. The graphic (below) highlights the nature of the shift in Saskatechwan.

Evolving Nature of Nursing Management


Primarily administrative focused
Distributed clinical/admin functions
Primarily clinically focused
15 Years Ago
5 Years Ago
Today

- **CLINICAL Manager**
  - Accountable for standard of care; staff support (primarily nursing); patient and family advocacy; coordination of care
  - Availability of skilled nursing staff
  - Districts: Single site / unit responsibility; direct supervisory support available
  - Additional supports available for role (educator, clerical)

- **Clinical / Administrative**
  - Same clinical accountabilities plus budgetary, reporting, project accountabilities
  - National shortage of skilled nursing staff; staff mix changes, International Educated Nurses (IENs), utilization of non-professional staff
  - Regions: Multiple site/unit responsibility; supervisor remote
  - Support for role almost non-existent

- **Clinical, ADMINISTRATIVE**
  - Increasing complexity of role, with increased administrative tasks and expectations
  - Increased clinical issues: Complexity of patients has increased, introduction of new technologies, access issues leading to shortened LOS
  - Increased focus on quality and safety and patient experience, introduction of numerous, simultaneous initiatives: Releasing Time to Care, LEAN, Safer Healthcare Now, Attendance Management, etc.

As depicted, Nursing Management experienced a shift from a clinical to an administrative focus with significantly expanded scope. Both literature and the stakeholders consulted report that this shift has had undesired consequences in the key areas of: patient care service delivery, staff management and work unit culture, as well as Nurse Manager job satisfaction.

Nurse Managers interviewed in this review reported that they feel a strong requirement for accountability and responsibility in their roles with little authority. Their roles have become increasingly complex with growing (and what they identify feels like "unmanageable") spans of control. The relevant findings related to Nurse Manager span of control are listed below.

- Nurse managers have an average of 99 direct reports provincially, where some Nurse Managers are required to supervise 200 staff who may work at more than one site, and represent a number of different job categories outside of Nursing (such as: Rehabilitation professionals, Social Workers, other disciplines, and support staff). Managers have limited ability for mentoring, coaching, supervision and staff development with this number of direct reports.

- Adherence to nursing practice standards is critical to quality patient care, as well as continual updating of research-based standards. Nurse Managers must ensure they are aware of practice changes, and ensure staff implements them in a timely manner.

- Increasingly, Nurse Managers have "out of discipline" staff (i.e. non-nurses) reporting to them. For many of these staff, there is a further requirement to have some knowledge of practice standards. This can be a challenge for Nurse Managers, particularly, where the Professional Practice Leaders per discipline are not readily available.

- With an increase in the complexity of patient care, and reliance on the high number of new and international educated nursing graduates, significant time is required for orientation and ongoing development of these staff. Managers reported that due to a lack of unit based clinical educators, these responsibilities fall to them, and they have insufficient time for this activity.

- Nurse Managers spend significant time performing non-managerial duties, which previously were done by clerical support. Many support roles have been eliminated with budgetary challenges in the 1990's, and the impact is limited resources to support nurse managers.

- Strong and growing provincial emphasis on excellence, quality, safety and putting the patient first, while commendable, has resulted in a multitude of initiatives (Releasing Time to Care, LEAN, Safer Healthcare Now, and IHI initiatives). There are limited resources for implementation support, which can impact the Nurse Manager who is required to champion, if not lead, initiatives. The change and implementation requirements are time consuming, and there are too many to be managed effectively, and to ensure sustainability. Nurse Managers say "everything is a priority".

- Nurse Managers are increasingly required to work longer hours and return to work outside of normal working hours, to assist staff with clinical and staffing issues. This creates work/life imbalance, and has a significant impact on manager job satisfaction.

- Many Nurse Mangers have limited educational preparation for the administrative components of their role, and there is limited opportunity for comprehensive orientation or ongoing professional development. Compounding this issue, many Nurse Managers are inexperienced: nearly 50% have less than 5 years experience; in large urban areas, 20% have less than 1 year experience.

Compounding these challenges, there is significant forecasted turnover for Nursing Management and limited attraction to the role. SAHO data demonstrates that 39% of Nurse Managers are eligible for retirement over the next 5 years. Nursing Management demographics show significant considerations:

- Number of Nurse Managers over age 51 (and eligible for retirement) is significant, and is evenly distributed: 45% in urban RHAs, 51% in non-urban RHAs, and 41% in the northern RHAs; and

- Nurse Managers with more than10 years in the role are considering retirement.

The consultation findings indicate that little or no succession planning is underway. Urban centres are somewhat optimistic regarding succession planning; in non-urban settings, Nurse Managers felt that few staff are interested in this role. Nurse Managers identified frustration that previous reviews have not brought discernable change. Overall, this employee group feels powerless to effect change.

Implications

The key challenge is to address 'freeing up' Nurse Managers' time so that they can apply more clinical focus. Reversing the undesired consequences of the Nurse Manager shift from predominantly clinical to predominantly administrative is a challenging and complex task for any jurisdiction, and no less for Saskatchewan, which has dispersed facilities, large geography, and limited resources to draw upon.

In order to enable the Nurse Manager to play a stronger and available leader role for staff and patients, the management model will have to focus on how the role can be re-scoped to a more manageable span of control.

Adopting a Transformation Roadmap - Opportunities for Saskatchewan

Thinking of the future

Implicit in the change opportunities is the need for courage. Leaders at all levels, (political, provincial and RHAs) must avoid the false notion that the Saskatchewan health sector is too unique, different or constrained to adopt innovative and creative solutions that are working elsewhere. The inevitable conclusion of this report is that the future of Saskatchewan's health system lies with adopting new ways of doing business. The opportunities developed have been analyzed and provide the basis for recommendations. Looking ahead, Saskatchewan's corporate health management structure should begin to adopt new operating models designed to provide a balance between local responsiveness and stronger, more centralized management structures designed to:

- Create economies of scale through the consolidation of repetitive transactional functions occurring across all RHAs;
- Promote standardized practices for current and new work processes to enhance effectiveness;
- Attract and retain required staffing for 'hard to find roles' to avoid the current and anticipated workforce challenges in many of the RHAs; and
- Provide consistent strategic leadership at a province-wide level.

This management transformation is intended to deliver increased value, address sustainability challenges across numerous smaller health regions, and, once in place, cost the system less. A further benefit gained is that the RHAs come together as a common enterprise, rather than a collection of independent entities. The future reduced costs can be used as an offset to the required investment to support the change and, in time, can be re-allocated to the patients and communities of Saskatchewan.

In order to create this future state, there are two types of opportunities facing Saskatchewan:

1. Transformational opportunities, which promote a different way of doing business and represent large-scale change; and

2. Enabling opportunities which exist at either or both the Ministry and RHAs, and provide:
    i) Improvements to the current state that should be undertaken;
    ii) Interim solutions between current and future state;
    iii) Foundation for transformation requirements to 'do business differently'; and
    iv) Transition requirements to support implementation of transformation opportunities.

While the transformational opportunities required additional work as concepts before they could be valuated and a preferred direction determined, it was agreed that the enabling opportunities were appropriate and they were transitioned to recommendations. Both transformational and enabling opportunities along with recommendations are presented in the next section of this report.

Transformational Opportunities

Given the magnitude of change in transforming Nursing Management and Corporate Administration, more than one way exists to bring about change. The table below presents the options examined for the transformational opportunities (details on the options can be found in the Appendix).

Area		Transformational Opportunities and Respective Options for Value Analysis
Nursing Management		▪ Determine whether a Clinical Front Line Leader or Clinical / Administrative Leader role is preferred based on the following considerations: – Clinical / Administrative Leader - Managers would continue in their current role, but with additional support to eliminate non-managerial tasks from their accountabilities, freeing up significant time for clinical leadership – Clinical Leader - requires majority of administrative tasks to be removed from Nurse Manager role. To facilitate this, significant managerial supports would be required organizationally to perform these administrative duties
Corporate Admin Back-Office Service Integration	HR	▪ Managed Service for HR delivered across three zones (hubs) in the province that provides transactional and strategic management HR services across the province OR ▪ Shared Service organization (Newco) that provides standardized transactional and strategic management HR services for all RHAs
	Finance	▪ Managed Service for Finance across three zones (hubs) in the province that provides transactional Finance services for RHAs OR ▪ Shared Service organization (Newco) that provides transactional Finance services for RHAs
	Supply Chain	▪ Explore options to centrally manage, coordinate, and / or deliver supply chain functions, such as: – Planning, Procurement, Logistics and Distribution, Inventory Management, Payment

To determine the highest value change option for Saskatchewan, a valuation framework with four value drivers and variable weighting (see below) was developed and validated with the Ministry to assess and determine the preferred transformation options before moving to recommendations. When considering each opportunity option, we examined the impact on Patient Focus, Workforce Focus, System Focus, and Feasibility.

Valuation Framework

Patient Focus (40%)

(Positively Impact Patients' Experience)

- Contributes to improving the patient's experience with the health system by measuring, reporting, analyzing, establishing and meeting / exceeding expectations about quality and coordination of services delivered across the continuum of care
- Supports customer engagement including clear service delivery expectations and targets for improved customer engagement and satisfaction
- Supports customer convenience (less travel, faster access)

Workforce Focus (20%)

(Generate Better Workforce Environment / Deployment / Recruitment)

- Strengthens people and talent management strategies (succession, recruitment, retention, development, competency development) to increase consistency across Province
- Builds workforce capacity to support system-wide adoption of a culture of efficiency, effectiveness, and patient-centred approaches that focus on creating more value for customers
- Strengthens provincial people strategy that supports allocation of resources to areas of high need
- Promotes adoption of alternative service delivery model that addresses sustainability and quality concerns

Preferred direction

System Focus (20%)

(Generates higher value delivery systems)

- Promotes reduction in current operating costs that can be reallocated to higher value service models through use of evidence and approach to improve access, efficiency, patient and provider satisfaction, etc.
- Addresses sustainability challenge and improves current service delivery and levels
- Supports stronger performance management, transparency and accountability that focuses on measurement and reporting, service delivery and achievement of outcome targets and strategic directions
- Increases provincial coordination and standardization

Feasibility (20%)

(Potential to implement)

- Ease of implementation (change management requirements)
- Cost to implement, including time to achieve return on investment
- Timeliness (length of implementation)
- Political considerations (elected officials, public, MOH)

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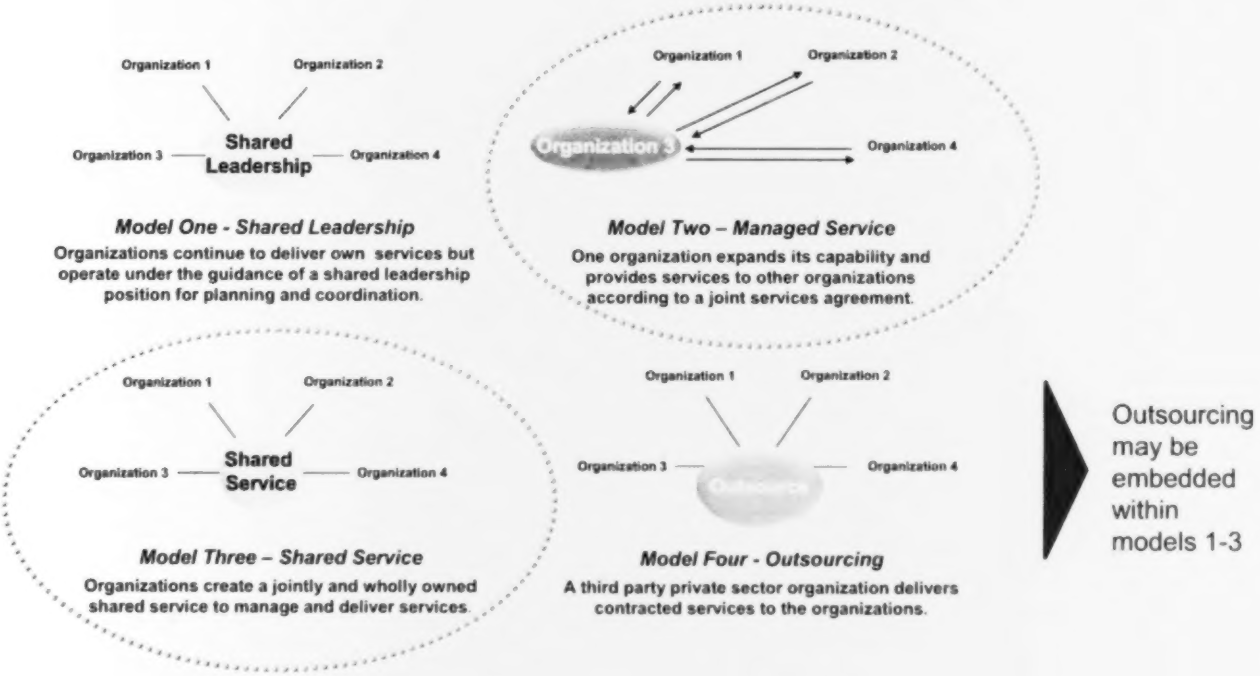
Administrative Services Opportunities: Back-Office Service Integration

Health organizations across the country are examining alternative service models to acquire cost savings for reinvestment. Multiple jurisdictions in Canada are exploring alternative service delivery models for corporate and support services. The graphic below outlines four different models of alternate service delivery, where potential savings and increased capacity can be realized. Given the higher degree of benefits realized through greater transformation, this review focused on the Managed and Shared Service models.

Alternate Service Delivery Models to Support Service Integration


Organization 1
Organization 2
Organization 3
Shared Leadership
Organization 4
Organization 1
Organization 2
Organization 3
Organization 4
Organization 1
Organization 2
Organization 3
Shared Service
Organization 4
Organization 1
Organization 2
Organization 3
Outsource
Organization 4
Outsourcing may be embedded within models 1-3

Model One - Shared Leadership

Organizations continue to deliver own services but operate under the guidance of a shared leadership position for planning and coordination.

Model Two – Managed Service

One organization expands its capability and provides services to other organizations according to a joint services agreement.

Model Three – Shared Service

Organizations create a jointly and wholly owned shared service to manage and deliver services.

Model Four - Outsourcing

A third party private sector organization delivers contracted services to the organizations.

The starting point, scope, and pace of service integration depend on the capacity and appetite for volatility, and the resources available to implement change. Supply Chain is a common starting point as the business case (and savings) often supports adoption of other shared services (such as Finance, HR). Examples of service integration considered in Canada and abroad include:

- Corporate Functions: HR, Finance, IT, Legal, Insurance (procurement), Information / Privacy, Infection Prevention and Control, Internal Audit, Physician Leadership and Medical Affairs, Communications; and
- Support Functions: Supply Chain, Facilities, Biomedical Engineering, Laundry / Linen / Housekeeping, Health Information Management, Food Services, Central Sterilization and Reprocessing.

In addition to corporate and support functions, service integration is also occurring in clinical programs and regional health structures:

- Clinical service integration and coordination within and across RHAs to ensure safe, sustainable (i.e. spending, workforce), high quality care that is accessible; and
- Regional Health Structures continue to evolve as seen most recently across Canada in Alberta (9 to 1) and New Brunswick (8 to 2) and in other jurisdictions such as: Denmark (15 counties to five health regions) and the UK (28 strategic health authorities to 10, and 350 Primary Care Trusts to 152).

Key value drivers for such service integration include:

- Saving costs via centralization, process standardization, and implementation of leading practices;
- Capital / cost avoidance (replacing dated information systems, infrastructure);
- Increasing service quality and safety – customer focus with clear accountability for performance;
- Refocusing resources (managers and staff within areas) to value-add activities; and
- Improving sustainability – financial (operating / capital), workforce, service quality.

For Saskatchewan, irrespective of the model selected (i.e. Shared Service versus Managed Service), the following are key requirements needed to support the change:

- Further business case development is required to validate savings and investment requirements. Savings and cost estimates are high level and based on other jurisdictions' experiences. They are provided for the purposes of model valuation.
- The role, mandate, structure, and governance of SAHO need to be examined in the Shared Service Model.

Recommendations

Transformational Recommendations (by area)

Nursing Management

Recommendation	Rationale
1. Introduce supports to the current Nurse Manager role that will allow increased focus on the patient and staff requirements.	Managers reported that the most satisfying components of their role are the impact they can make on patient care, and staff development. Appropriately assigned managerial tasks can still be accomplished within the current role where non-managerial clerical type tasks are removed from their accountabilities. Based on the option valuation approach, the current Clinical / Administrative Leader was the preferred option (over the Clinical Leader) because it requires less of a culture change and is less costly to devolve non-clinical activities. The alternate Clinical Leader option required significant culture change and investment (one time and operating). While both models need investment to support Nurse Manager effectiveness: ▸ The preferred model (Clinical/Administrative Leader) has approximate costs of $500k in capital and $2.5M to $3.5M annual operating costs (which have been arrived at by estimating the capital and operating costs required to support this model); ▸ The Clinical Leader option (not selected) requires same capital cost ($500K), an additional upfront change management investment of $1M, and higher annual operating costs of $5M-$7M (because this model has another level of management). **Key considerations for implementation:** Required investments for the preferred option may be supported by: 1.Reallocation of resources through pending service integration changes and associated savings, and 2.Examination and potential realignment by RHAs of organizational structures at the VP and Director levels across system (as there are 45+ VPs and 400+ Directors in all corporate and clinical sectors that account for $7M and $38M in annual compensation spend system-wide. Note: Changes to organization structure should be directed by RHA executive leadership based on their respective organizational requirements.

Supply Chain, Human Resources, Finance

Recommendations	Rationale
1. Establish a single Provincial Shared Services Organization for Supply Chain, Human Resources and Finance functions, which will require the following: a) Detailed service model design, and business case, implementation plan, and transition support focused on people, work process, technology, and change management requirements); b) Defined governance, mandate, role, organization and operating structure, for the Provincial Shared Services Organization; and c) Alignment / integration plan for SAHO functions and staffing within the mandate of the Provincial Shared Services Organization.	Based on the valuation of both Shared and Managed Service options, the preferred option is a Shared Service Organization Model. This result was driven by higher value weightings in Workforce (i.e. capacity / sustainability) and System (i.e. savings for reinvestment, sustainability, coordination / standardization) quadrants. Other considerations include: ▶ Enhanced economies of scale and scope through increased integration, and enablement of system / process standardization (aligned with leading practices); and ▶ Shared Service Model is more feasible politically from the perspective of RHAs (compared against the managed service model). Potential savings from operations in this model will yield the greatest dollar reinvestment available for reallocation to enhance the patient experience. Savings estimates as percentage of operating costs are 14-20% for a shared service model versus 12 – 17% a managed service model – with a payback of 4 to 5 years. Estimates are high level and based on Deloitte's experience in other organizations / jurisdictions. **Key Considerations:** Additional time / effort / cost may be incurred for implementation through process / system standardization and development of a gain sharing model across 14 entities (i.e. ensuring appropriate allocation of potential savings across all participating organizations). Investment estimates (capital and transition support) as percentage of operating costs for Finance, HR, and Supply Chain are similar over five years: 19-26% for a shared service versus 17-24% for a managed services. Estimates are high level and based on Deloitte's experience in other organizations / jurisdictions. As the future service delivery model is designed for a shared service organization in Finance, HR, and Supply Chain (and the associated scope of services are determined), the following considerations will need to be addressed: ▶ The mix of services to be provided in the shared service entity (a range of transactional services that are duplicated across regions, selected strategic services, and those services currently provided by SAHO. ▶ Overlap during the transition period to a single Shared Services Organization – in all organizations. ▶ SAHO does not currently have the capacity / capability to take on these shared services. ▶ Stakeholder consultations revealed that SAHO's current structure and governance model is limiting the value SAHO could potentially provide to its member organizations (i.e. quality of service, scope) – and would need to change irrespective of whether or not SAHO assumes an expanded role.
2. Accelerate selection and implementation of a single HRIS for the province (which will support Provincial Shared Services Organization).	SAHO has already engaged in a collaborative process with RHAs to formulate a business case for a provincial HRIS. Documented benefits include: supporting the reduction of manual, labour intensive work processes, and increasing process standardization, improving data quality.

General Administration

Recommendations	Rationale
1. Realign executive and management structures at the RHA level, with a focus on consolidating executive roles and/or shared leadership roles where appropriate.	As the province moves to a Provincial Shared Services organization, RHAs should determine the most appropriate executive structure required in its corporate areas – where non-urban RHAs may not require separate executive leadership roles in each area of HR, Finance, and IT. Further, many non-urban RHAs have 2 clinical executive leaders – which could be integrated given: 1) the recommended additional supports in place for Nurse Managers which should alleviate the identified span of control challenges; 2) inconsistency in clinical leadership ratio across the province (i.e. direct reports, budget, population served), and 3) potential benefits of integration at the VP level across clinical programs.
2. Increase physician leadership roles across the province, with particular emphasis on increasing and establishing a standardized FTE allocation (i.e. 0.5 FTE to 1 FTE) for Senior Medical Officer (SMO) roles for non-urban regions.	Physician leadership roles in non-urban RHAs are highly variable in terms of allocation. Increased leadership is required to support change and accountability requirements.

Information Technology

Recommendations	Rationale
1. E-Health council should prioritize its development of the eHealth strategic plan and have in place by Dec. 01, 2009 (to enable and cascade operational requirements at the provincial and RHA levels).	Supports the need for continued and enhanced focus on the eHealth agenda for Saskatchewan. Advancing the eHealth agenda will require continued and potentially increased investment to realize the benefits of an e-HR. Enhances and standardizes service delivery structure for IT services across RHAs. Maintains pivotal role for HISC related to eHealth strategic planning and implementation. Given the range of current service models across RHAs, IT delivery (managed service, outsourced), there is a need to determine best go-forward provincial service strategy for IT at the RHA level. Additional review is required as the scope of this review could not include this level of additional work and detail.
2. Determine RHA requirements to advance e-HR agenda, as well as RHA ongoing IT requirements to maintain business and clinical requirements.	
3. Determine preferred service delivery structure for IT at the RHA level that focuses on the following options: a) HISC as an expanded service provider; b) A Managed Service structure that may chose selective outsourcing for commoditized IT functions (such as data centre, help desk); c) A Shared Service structure that may chose selective outsourcing for commoditized IT functions (such as data centre, help desk); other structures; d) Combination of the above options 4. Secure and stabilize funding for both the provincial e-HR requirements and RHA implementation requirements.	

Enabling Recommendations

Enabling recommendations are provided by area, and should be staged to support the transformational recommendations. Staging of enabling recommendations will vary; some will precede, parallel or follow transformational recommendations.

Nursing Management

Recommendations	Rationale
1. Establish a provincial recruitment program for skilled nursing staff.	Currently, most Regions are engaging in recruitment activities and competing for the same staff. The outcome of this in the current regional delivery system is duplicative activity in addition to significant workload for busy Human Resource Departments and Nursing Managers. Will support smaller regions that are taxed to support the growing efforts in this area. This should be incorporated into the Provincial Shared Service Organization – once established.
2. Provide technology supports, such as increased access to printers, Telehealth, wireless laptop computers, PDAs (Blackberry), and desktop videoconferencing.	There is need to ensure the front line managers are enabled for enhanced effectiveness. Such supports are for onsite effectiveness as well as off site/unit responsiveness for managers who have to travel between sites/units.
3. Develop provincial service improvement teams that can travel to regions to support: a) Information and practice sharing; b) Regional project implementation support; c) Cross region/province collaboration; and d) Change initiative coordination.	To provide increased support at the regional level for standardized implementation – where areas of focus / support could include development or implementation of: ▶ Clinical practice guidelines; ▶ Standards of care; ▶ Quality / patient safety policies; and ▶ Other provincial initiatives (i.e. releasing time to care).
4. Develop a Nursing Management Resource Team at provincial level that supports: a) Organizations with medium to long term manager vacancies; b) New hire (1 to 3 months) transition (coaching); and c) Ongoing management education and professional development opportunities.	Provincial resource group that extends across province to support nursing management requirements where there are identified challenges will alleviate pressures at smaller regions. Cadre of strong Nurse Managers across province who could fill these roles. Many managers are nearing retirement; a role of this nature would retain their expertise in the system. Providing current managers with support for orientation, ongoing development, and relief so that managers could access professional development opportunities off-site, will increase job satisfaction and enhance recruitment into the role.

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Recommendations	Rationale
5. Identify potential management-staff compression issues for the Nurse Manager role, which will include considering job descriptions, compensation levels, and Joint Job Evaluation (JJE) classifications.	Recent compensation adjustments for Nurse Managers (as a result of requirements to align with the recent SUN agreement) may not be sufficient to address the "total compensation" gap - when shift / weekend differential, responsibility pay, overtime and education allowance are considered for frontline nurses – suggesting a required focus on job classifications MCP4 and MCP5. There is a need to identify staff-management compression issues, and ensure that Joint Job Evaluation (JJE) for Nurse Managers accurately reflects the role complexity.

Finance

Recommendation	Rationale
1. Audit mapping of payroll data to RHA financial accounts.	Data challenges observed and experienced in this review process suggest that the RHAs are not following standardized mapping. The benefit for the Province will be stronger consistency for future comparisons.
2. Conduct an MIS audit to enhance the quality / comparability of information across organizations.	Data challenges observed and experienced in this review process suggest that an audit of reported data is required.

Human Resources

Recommendation	Rationale
1. Establish a talent management strategy for managers (across all disciplines), that focuses on recruitment and retention practices and incentives, learning and development of current and future cadre, succession planning, and performance management.	To provide learning and development opportunities for current and future management / leader cohort.. Improvement opportunities include: ▶ Mandatory orientation for new managers; ▶ Increased management / leadership courses for current managers; ▶ Increased networking opportunities for managers across Regions; and ▶ Developing and / or supporting the cohort of new managers to enter the system. This should be incorporated into the Provincial Shared Service Organization – once established.

Recommendation	Rationale
2. Align provincial workforce strategic planning initiatives with upcoming provincial clinical service planning (linked to current provincial work underway to establish sustainable service delivery models across the health care continuum, and in particular in rural and northern Saskatchewan).	RHAs have reported difficulty recruiting and retaining qualified clinical staff (including physicians) across urban, non-urban, and remote areas. In extreme situations, this has resulted in service closures – either periodically and in some cases permanently. Future workforce planning for all areas / disciplines (i.e. clinical and non-clinical) should be aligned with a renewed provincial clinical service delivery redesign. The types and distribution of services need to align with evidence-based population health needs, Patient Experience review findings, and workforce sustainability considerations (available workforce, quality of care, patient safety and cost). Clearer defined service model across Saskatchewan should be aligned to the provincial workforce planning to support new models of service.

Telehealth

Recommendation	Rationale
1. Expand the Telehealth clinical programming across the province through the following mechanisms: a) Assess business case of Telehealth expansion on a clinical service / program basis that will enhance access and reduce travel requirements and costs for patients and families; b) Develop provincial scheduling solution for Telehealth sessions and corresponding work processes to increase service coordination and ease of access; and c) Develop provincial clinical adoption strategy that includes resources to support transition.	Increased Telehealth programming for clinical care will: ▶ Enhance patient access and convenience, and reduce travel requirements; and ▶ Support alternative clinical service delivery redesign.
2. Expand Telehealth or other mechanisms (such as desk-top video conferencing and video archiving of educational sessions) in rural communities for administrative and training and development purposes considering enhanced patient access, reduced travel and savings in travel and accommodation for staff and patients.	Increased application of Telehealth or other mechanisms will reduce the need to travel to meetings or educational events, provide easier access to for clinical, educational, and administrative functions, which will promote greater end-user adoption while mitigating the requirements for other more costly telehealth infrastructure.
3. Explore business case for future clinical expansion that includes: a) Advanced applications of Tele-home care; b) Tele-monitoring to support enhanced access considerations; and c) Piloting new applications in rural/northern communities and link to advancing chronic disease management strategy.	Increased Telehealth programming for clinical care will: • Enhance patient access and convenience; • Reduce travel requirements; and • Support alternative clinical service delivery redesign.

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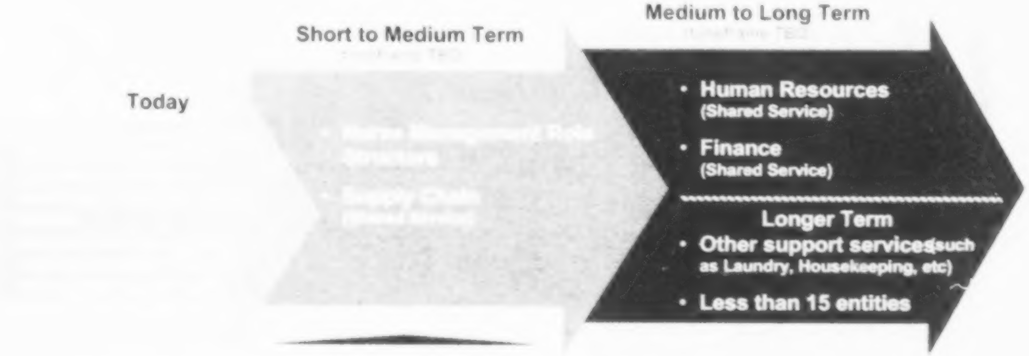
Recommendations staging

The diagram (below) provides a framework to guide transformation to service integration over the next 5 years. This change journey requires Saskatchewan's health care leaders and providers (i.e. RHAs and SCA) as well as political leaders to shift their perspective from an organization-centric to a system view.

In the short to medium term, the initial focus for service integration should be on supply chain. Commonly, across other jurisdictions, supply chain is the starting point and can provide a foundation to support medium to longer-term service integration opportunities such as Finance and HR. The future role and mandate of SAHO will need to be considered in parallel. At the same time, changes to Nursing Management should begin as well. Provincial and RHA requirements for IT service delivery should be considered and factored into the future state planning.

Framework to Guide Transformation


Medium to Long Term
Timeframe TBD
Short to Medium Term
Timeframe TBD
Today
Nurse Management Role Structure
Supply Chain
(Shared Service)
Human Resources
(Shared Service)
Finance
(Shared Service)
Longer Term
Other support services(such as Laundry, Housekeeping, etc)
Less than 15 entities

IT service structure for province determined at RHA level

SAHO role will need to be defined in the go-forward model

Savings achieved through Supply Chain can enable key Nurse Manager support requirements such as clerical support, technology enablement, and professional development. Longer-term transformational activities may also include the examination of other key support services, and greater integration across regional structures in the province.

It is important to note that the selection of preferred models was supported by high level investment and savings estimates. Significant work will be required related to the detailed design and business case for shared services in the province across Finance, HR, and Supply Chain – including the review and determination of SAHO's role going forward.

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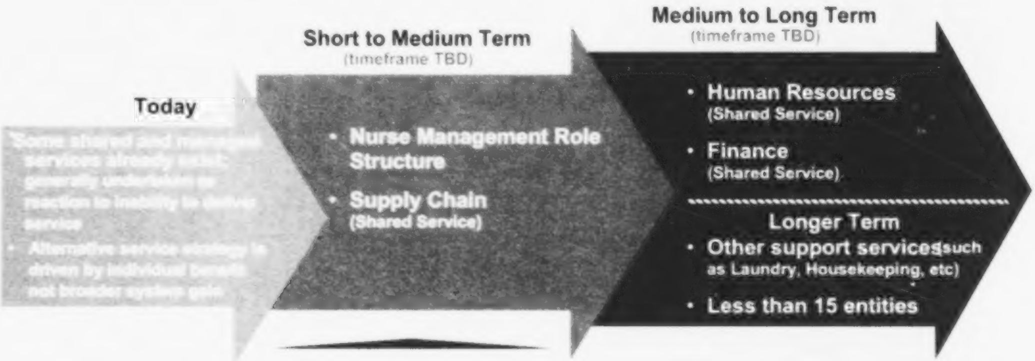
Today
Some shared and managed services already exist; generally undertaken in reaction to inability to deliver service
Alternative service strategy is driven by individual benefit not broader system goals
Short to Medium Term
(timeframe TBD)
Nurse Management Role Structure
Supply Chain (Shared Service)
Medium to Long Term
(timeframe TBD)
Human Resources (Shared Service)
Finance (Shared Service)
Longer Term
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Summary

The primary question in the Administrative Review was whether Saskatchewan's current health system is 'over' or 'under' managed. While the province's relative level of resourcing for combined Administrative areas (which includes General Administration, Finance, Human Resources, and Information Technology) is lower compared to Canadian jurisdictions, there are a number of considerations that provide important insights:

- Low relative resourcing is driven by General Administration and IT, and does not necessarily represent efficiency, effectiveness or value.
- While General Administration spend is lower compared to Canadian jurisdictions, Saskatchewan has greater relative spend on board and executive costs, which leaves fewer resources for key General Administration support functions such as strategic planning / decision support, quality / risk management, and patient safety.
- Lower IT resourcing translates to insufficient resourcing across RHAs, where IT is not able to meet the business requirements in many organizations, and will be challenged to support the provincial eHealth strategy going forward.
- Finance and Human Resources have higher relative resourcing compared to Canadian jurisdictions. These functions are largely transactional in nature, particularly in the non-urban regions, and the needs of internal customers (i.e. managers / employees) are reportedly not being met.
- Current corporate management model is not sustainable from a workforce perspective. In particular, Finance, Human Resources, and IT functions are experiencing and anticipating recruitment and retention challenges of qualified leadership and frontline staff.
- Economies of scale are challenged given the duplication of transactional functions across 14 service provider organizations.
- Lack of consistent strategic leadership is evident across provider organizations.

In simple terms, while Saskatchewan is spending less than other Canadian jurisdictions on an overall basis in its corporate management of the health system, it is receiving questionable value for money. This is not an outcome of the leadership; it is the health regions configuration that limits the ability for significant gain. In addition, the sustainability challenges experienced by many of the RHAs raise a further question of viability. All of this points to a strong need to reconsider the current regional structure, an area outside the scope of this review. Meanwhile, the Province does not need to stand still. Regional Health Authorities can do things differently in the interim. The recommendations in this report are not about changing the business, but rather conducting business differently so that the system is more efficient, effective and sustainable.

Leading and sustaining change should be a priority for Provincial Leaders, Senior Management and Boards of Regional Health Authorities. Given the magnitude of transformation recommended in this report, 'making it happen' is no small task. However, inaction is not an option. At the heart of the recommended change, the goal is to generate new service models that consolidate centres for transactional activities, creates stronger more centralized strategic management, and maintains local support at the RHA level. The outcome of this transformation is a more cost effective delivery system that delivers higher value, addresses the growing sustainability challenge across numerous smaller regions, and, once in place, costs the health system less.

Success is dependent on accepting change and gaining further clarity on what the new system will look like and the detailed support requirements. The good news is that precedents exist to achieve this future state. However, strong desire for change alone will not bring success. Without well planned and supported execution, breakthrough thinking falls apart, and little to no value is added. As the province and RHAs work as partners to change and improve the way they conduct business, it is imperative to think hard about execution. This means heeding lessons from other jurisdictions and tailoring them to Saskatchewan. It also means understanding what services the regions need and how they need to be delivered to be acceptable. Collaboration is key. The Province should look to partners in other jurisdictions and sectors. Most importantly, the Province and the multiple stakeholders should begin to view the Regional Health Authorities as a common enterprise, rather than a collection of independent entities.

The findings and corresponding recommendations provide a future vision for Saskatchewan. A detailed strategy for execution which bridges theory and practice will help the province get there. For Saskatchewan to be successful in this transformation, investment is required along with strong leadership and performance management.

Appendices

Transformational Opportunity Option Descriptions

Nursing Management Opportunity: Nurse Manager Role Redesign and Enablement

The national trend for Nursing Management, also evident in Saskatchewan, has seen a shift from clinical focus to an administrative focus with significantly expanded scope. The key challenge and goal is to '"free up" Nurse Managers time so that they focus more on the patient care accountabilities associated with their role, and are available to staff for mentoring, coaching and staff development. The two options developed focus on different approaches to adjust the Nurse Manager role.

Option 1: Clinical / Administrative Leader

Managers continue in their current role, with additional support that allows them to shift the focus from administrative to more clinical in nature. The goal is to allow Nurse Managers to refocus on patient care and staff leadership. This shift is achieved through the assignment of appropriate corporate / administrative tasks and functions to the most appropriate level of staff in the correct organizational area, and other key enabling supports, such as:

- Additional clerical support to facilitate relinquishment of non-managerial responsibilities to a more appropriate level of employee;
- Nurse Management Transition Resource Team, to assist with orientation and mentoring of new managers;
- "Out-of-Scope" Assistant Patient Care Manager or Clinical Supervisor to relieve some of the managerial burden for managers, and facilitate a mentoring process for those interested in nursing management positions in the future;
- Technology enablement, to facilitate timely communication between staff and managers when managers are required to be off-site; and
- Enhanced support from Finance and HR to ensure staff from these areas perform non-managerial transactional activities associated with these corporate areas...

Option 2: Clinical Leader

Nurse Managers would relinquish most of their administrative tasks, and assume a clinical leader role (similar to ward sister in United Kingdom model), thereby shifting to a full clinical focus. Following the UK model, a new level of administration would be required between the Director and Nurse Manager level (Matron as in the UK or likely another name) for every three to four clinical Nurse Managers. The Clinical Nurse Manager would be responsible for:

- Budget compliance for the unit;
- Staff mentoring and supervision;

- Daily staff scheduling assignment;
- Patient care coordination; and
- Patient and family concerns.

The new level of management (called the 'Matron' in this review) would be responsible for:

- Budget development and monitoring for group of units;
- Business planning;
- Scheduling;
- Attendance management;
- Performance appraisals, hiring, firing, labour relations;
- Liaison with support services and departments to ensure clinical needs are met;
- Equipment procurement;
- Policy research and development; and
- Committee attendance.

Administrative Services Opportunities: Back-Office Service Integration

Based on our review of Administrative functions in Saskatchewan, which revealed higher levels of resourcing for Finance and HR (compared to other jurisdictions), and workforce sustainability and service quality issues, Finance and HR are key candidates for service integration. In addition, Supply Chain is added to this opportunity given its linkage with Finance functions (i.e. Accounts Payable), and the potential savings through centralization of Supply Chain across the Province. Experiences from other Canadian jurisdictions demonstrate that Supply Chain integration supports the business case for further service integration across Finance and HR – and beyond. Two options were considered for back-office service integration:

Option 1: Shared Service

Shared Services involves the creation of a new entity for the province, and builds on the foundation established by SAHO. It would support transactional (and some strategic) Finance, HR, and Supply Chain functions / activities. Shared Services entity could be structured with the following components:

- *Service Centre:* Transactional activities are centralized through a Service Centre (i.e. HR self-service, HR administration, A/P, GL, standardized analytics / reporting)
- *Centres of Expertise:* Centralized experts supporting key strategic functions, providing consulting and strategic advice to business advisors regarding labour relations, total rewards, talent acquisition and development, disability management, business planning
- *Local Business Advisors:* Local support would be available for Finance and HR across RHAs, aligned by organizational structure, and enabling strong client relationships, deep business knowledge, and cascading standardize work processes and solutions at the client organization

An ERP system and operational process standardization will be a key enabler to support integration. Similar to Option 1, Supply Chain is sequenced first; Finance and HR systems / process standardization could occur in tandem. The approach to determine estimated savings is similar to the Managed Service option; however, the estimated magnitude of savings is greater in a Shared Service due to increased consolidation, standardization, and critical mass in the Shared Service model.

Option 2: Managed Service

A Managed Service model would entail the creation of 3 managed service hubs or "zones" (i.e. North, Central, South) for Finance, HR, and Supply Chain functions / activities. In this option, each of the three service providers would rollout their respective service delivery models currently, which may include a transition to a model that is a hybrid of centralized and local support (see table below). An ERP system and operational process standardization at the zone level will be a key enabler to support integration. Supply Chain would be sequenced first, with Finance and HR systems / process standardization occurring in parallel.

Savings estimates for Supply Chain are based on integration of procurement functions, and potential savings associated with increased product standardization and group purchasing. Aspects of end-to-end supply chain would be considered in design / business case development in year 1.

Savings estimates for Finance and HR are based on comparing the relative performance of service providers (i.e. RHAs) in the system versus performance of potential service hubs in the system.

For both options, there are several functions / activities across HR, Finance, and Supply Chain that can be considered in either a managed or shared services model. The table below indicates which activities would be part of the managed / shared services model and which would be retained locally by independent health care organizations.

Function / Area	Sub-Function / Activity	Considered for:	
		Managed Service (North, Central, South Zones)	Shared Services
Finance	General ledger		
	Asset Management		
	Accounts Receivable		
	Accounts Payable	**Yes**	
	Payroll		
	Reporting / Analytics (some)		
	Finance Business Advisors	**No (Retained Locally)**	
	Financial Stewardship – CFO		
Human Resources	Compensation / Benefits		
	Attendance Mgmt		
	OH&S		
	Organizational Development	**Yes**	
	Employee Relations / Labour Relations		
	Talent Management (recruitment / retention, workforce planning, performance management)		
	HR Business Advisors	**No (Retained Locally)**	
Supply Chain	Planning / Procurement	**Yes**	
	Distribution & Logistics	(Procurement / Sourcing would be centralized across system in both models – other supply chain functions would be considered in design / business case phase)	
	Inventory Management		
SAHO	Payroll / Pay Processing	**No**	**Yes**
	Benefits Administration		
	GPO		
	Labour Relations		
	Provincial programming (i.e. Occupational Health and Safety, Organizational Development)		

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